U.S. ARMY FAMILY ADVOCACY PROGRAM

SPOUSE ABUSE MANUAL

Case Management ❖ Assessment ❖ Treatment ❖ Follow-up

This material was developed for the U. S. Army Community and Family Support Center, Family Advocacy Program by staff of the Family Life Development Center in cooperation with Cornell Cooperative Extension, Cornell University, Ithaca, New York. The material is based upon work supported by the Extension Service, U. S. Department of Agriculture, under special project number 92-EXCA-3-0221.

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY MEDICAL COMMAND
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REPLY TO
ATTENTION OF

MCHO-CL-H (608-18a)

18 JUN 1996

MEMORANDUM FOR Commanders, MEDCOM HSSAs/MEDCENs/MEDDACs

SUBJECT: Spouse Abuse Manual

1. We enclose a reference guide for the management of spouse abuse cases entitled, "Spouse Abuse Manual: Case Management, Assessment, Treatment, and Follow-up." The purpose of this manual is to provide guidance for the implementation of a standardized spouse abuse assessment and treatment program for spouses, offenders, and children who witness domestic violence. The manual is designed to supplement Army Regulation (AR) 608-18, The Army Family Advocacy Program (FAP), and to ensure that a comprehensive spouse abuse program exists at all installations.

2. The following eight components were used as guides during the development of the manual:

a. Department of Defense (DOD) Family Advocacy Goals for year 2005.

b. Spouse abuse procedures found in AR 608-18.

c. Assessment procedures to identify children who witness domestic violence.

d. Five levels of spouse abuse with corresponding treatment and command recommendations.

e. Definition of mutual spouse abuse which is distinguished from self-protection.

f. Use of both psycho educational and clinical treatment options in a treatment plan. Included in psycho educational intervention is the victim advocate, victim witness program transitional compensation, the New Parents Support Program, First Steps, and numerous local specific programs.

g. Assessment based emphasis on outcome.

h. Incorporation of Quality Management procedures and measurements to include Quality Management indicators, AR 5-1,

MCHO-CL-H
SUBJECT: Spouse Abuse Manual

Total Army Quality, The Joint Commission on Accreditation of Healthcare Organizations standards pertaining to spouse abuse and DOD 6400.1-M, FAP standards.

4. We anticipate this manual will serve as an operational guide in the implementation of a program designed to assess, treat, prevent, and evaluate outcome services for spouses who have experienced abuse.

5. Our point of contact is Mary W. Behrend, Human Resources Management Division, Directorate of Clinical Operations, DSN 471-6767 or Commercial (210) 221-6767.

FOR THE COMMANDER:

Encl
as

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CHAPTER 1

INTRODUCTION

1.1 Purpose
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1.4 Manual

1.1 **PURPOSE**: To provide program guidance to implementing a standard comprehensive, quality spouse abuse treatment program in the U.S. Army for spouses, offenders, and children who are abused, neglected, or who witness domestic violence.

1.2 **References:**

a. Public Law 93-247, Child Abuse Prevention and Treatment Act of l974.

b. Public Law 95-266, The Child Abuse Prevention and Treatment and Adoption Program Act of l978.

c. Public Law 97-291, Victim and Witness Protection Act of l982.

d. Public Law 101-647, Crime Control Act of l990.

e. Child Abuse Prevention and Treatment Act (re-authored l984).

f. Title 10, United States Code, Section 2683.

g. DOD Directive 6400.1, Family Advocacy Program.

h. DOD Directive 6400,2, Child and Spouse Abuse Report.

I. DOD Directive 6400.3, Family Advocacy Command Assistance Team.

j. AR 608-l8, The Army Family Advocacy Program.

1.3 **AR 608-I8:** This regulation establishes the Department of Army policy on the prevention, identification, reporting, investigation, and treatment of spouse and child abuse.

1.4 **MANUAL:** This manual addresses spouse abuse.

a. It is recognized that spouse abuse and child abuse are often interrelated. Both may occur together or at different times in the same family. Children may be affected by domestic violence when they witness spouse abuse.

b. Objectives include:

(1) Ensure safety of the victim. Short and long term services are provided to protect victims and at-risk family members.

(2) Prevention of abuse. Prevention is addressed by providing services to both “at-risk” families and to victims of abuse including the offender.

(3) Provision of clinical treatment and intervention services, such as psycho-educational interventions, victim’s witness program, and new parent support programs, are combined to provide a comprehensive treatment program for both victims and offenders.

c. Concepts include:

(1) Assessment driven treatment and a comprehensive program are essential for prevention and treatment of spouse abuse.

(2) The offender is held responsible for his or her behavior. Responsibility includes realization that abuse is not acceptable behavior, a change in behavior is necessary and expected, intervention is required, and reparation for damages may be necessary.

(3) Coordinated systems approach is employed: Policies, procedures, and agencies work together to maximize the effectiveness of the program.

(4) Treatment and program administration are consistently evaluated to ensure program effectiveness.

FAMILY ADVOCACY PROGRAM: SPOUSE ABUSE

2.1 Army Family Programs
2.2 Family Advocacy Program

2.1 ARMY FAMILY PROGRAMS:

a. The Army is an institution, not an occupation or a job. As an institution, the Army has a moral and ethical obligation to those who serve and to their families. They in turn have responsibilities to the Army.

b. Families have an important impact on the Army's ability to accomplish its mission. A crucial human goal of the Army is to foster wholesome lives for military families and the community in which they live.

c. There are a number of family programs which contribute to the wellness of the Army family. One such program is the Family Advocacy Program identified in AR 608-I8 entitled, "The Army Family Advocacy Program." The Family Advocacy Program is a vigorous proactive program designed to address child abuse and neglect and spouse abuse.

2.2 FAMILY ADVOCACY PROGRAM:

a. The primary goal of the Family Advocacy Program is to prevent abuse by providing a variety of services to strengthen Army families and enhance their ability to adapt to military life. The aim of the Family Advocacy Program is to protect those who are victims of abuse, to treat families affected by abuse, and to assure the availability of highly trained professionals to intervene in spouse and child abuse cases.

b. Appropriate intervention requires coordinated actions by both the military and civilian com-

munity which are guided by:

(1) Multidisciplinary interventions based upon standards of practice and current research knowledge which are designed to stop violent and abusive behavior permanently.

(2) Policies and procedures that create a collective, community wide effort to help and assist families.

(3) Networking that joins the expertise, knowledge, and ability of all intervenors into an effective response on behalf of victims and their families.

(4) Quality Management procedures which assess the effectiveness of intervention and the consistency of intervenor application of established policies and procedures.

(5) Securing and managing resources for victims that reduce their vulnerability to and dependence on abusers.

(6) Accountability for offenders that is based on sanctions and, where appropriate, rehabilitation.

(7) Provision of highly trained professionals to implement the program and to provide treatment.

CHAPTER 3

SPOUSE ABUSE: DEFINITIONS

3.1 Army Family Programs
3.2 Famiily Advocacy Program—Spouse Abuse
3.3 Definitions
3.4 Indicators of Abuse: Mild, Moderate, Severe

3.1 SPOUSE ABUSE PROGRAM OBJECTIVE:

a. Identify and assess possible victims of abuse.

b. Stop the abuse.

c. Provide the victim immediate safety, long-term protection and support.

d. Provide state-of-the-art intervention and treatment for the spouse, offender, and children.

e. Hold offender accountable.

f. Apply system-wide policies and procedures.

g. Implement Quality Management procedures to ensure compliance to established standards of practice and program compliance.

3.2 FAMILY ADVOCACY PROGRAM-SPOUSE ABUSE: The following concepts embody the philosophical framework concerning spouse abuse.

a. Violence against a spouse is unacceptable.

b. Violence is often a tactic used to maintain power and control.

c. Spouse abuse is a widespread social phenomenon. Early interventions may effectively break the cycle of violence. Abusive behavior is learned, can be unlearned, and can be ameliorated through an effective intervention program.

d. A soldier who engages in spouse abuse cannot be considered a good soldier. The soldier is responsible and accountable for his or her abusive behavior and this behavior is contrary to the CORE VALUES and standards for personal excellence in the Army.

e. Soldiers who perpetrate multiple, subsequent incidents of abuse or who commit severe abuse will be recommended for administrative separation from active duty (see level 5 abuse in Appendix I and Chapter 5).

f. Victims of domestic violence have the right to take reasonable actions to protect themselves and to be protected from abuse.

g. The integrity and autonomy of the victim must be supported.

h. A consistent, coordinated team response is required in ALL incidents of spouse abuse.

i. Spouse abuse is a criminal act.

j. The rights of the alleged offender must be respected and preserved.

k. Spouse abuse is not caused by substance abuse.

l. Spouse abuse is not a "private" affair or strictly a family matter. It is a community issue and necessitates a community response.

m. The battered victim (spouse) does not cause the abuse or merit the abuse by behaving in ways that are unacceptable to the spouse.

3.3 DEFINITIONS:

a. **TYPE OF VICTIM - SPOUSE:** Identifies the victim as a partner in lawful marriage, when one or both of the partners is a military member employed by DOD and eligible or authorized for treatment in a medical treatment facility. A married person under 18 years of age shall be treated in this category.

b. **SPOUSE MALTREATMENT/ABUSE:** An assault, a battery, a threat to injure or kill, any other unlawful act of force or violence, or emotional maltreatment inflicted by one spouse in a marriage against the other when the victim, regardless of age, is authorized treatment in a medical facility of the military services. Emotional maltreatment is conduct which, although not criminal, is so offensive to the victimized spouse that a reasonable person would find such conduct abhorrent within a marital relationship. This includes all of subparagraph c, d, e, and f.

c. **SPOUSE PHYSICAL ABUSE**: Use of physical force that caused physical injury to the spouse. Violence is generally used to intimidate, control, or force the spouse to do something against his or her will. This may include grabbing; pushing; holding; slapping; choking; punching; sitting or standing on; kicking; hitting with objects; and assaults with knives, firearms, or other weapons.

d. **SPOUSE SEXUAL ABUSE**: The forcing of one spouse by the other spouse to engage in any sexual activity through the use of physical violence, intimidation, or the explicit or implicit threat of future violence, or abuse.

e. **SPOUSE EMOTIONAL MALTREATMENT**: A pattern of acts or omissions, such as violent acts that may not cause observable injury, that adversely affect the psychological well-being of the victim. Arguments alone are not sufficient to substantiate emotional maltreatment. Adverse impacts could include low self-esteem, chronic fear or anxiety, conduct disorders, affective disorders, or other cognitive or mental impairment. Includes:

(1) Psychological violence is a pattern of behavior involving one or more of the following behaviors: explicit or implicit threats of violence, extreme controlling types of behavior, extreme jealousy, mental degradation (name calling, etc.), and isolating behavior.

(2) Property violence by one spouse may constitute emotional abuse if intended as a means to intimidate the other spouse. Property violence includes, but is not limited to, damaging or destroying the other spouses property, hitting/kicking a door or wall, throwing food, breaking dishes, and intentionally or recklessly damaging automobiles. Threatening injury to or injuring pets is included in this category.

f. **SPOUSE NEGLECT**: Considered only in cases of spouse's failure to provide necessary care or assistance for spouse who is incapable of self-care physically, emotionally, or culturally.

g. **MUTUAL ABUSE:** Mutual abuse involves an attempt by a married couple to exert control over each other through violence, fear, or intimidation. Mutual abuse is differentiated from self- defense wherein one party, under assault, acts to protect self/family members, to defend against, and/or to escape an abusive situation.

3.4 INDICATORS OF ABUSE-MILD, MODERATE AND SEVERE: Some indicators of abuse include:

a. Mild Spouse Abuse

(1) Spouse verbally threatened.

(2) Mild physical injury or no medical treatment indicated.

b. Moderate Spouse Abuse

(1) Something thrown at spouse.

(2) Spouse pushed, grabbed, or shoved.

(3) Spouse slapped.

(4) Spouse kicked.

(5) Spouse kicked, bitten or hit with a fist.

(6) Minor or major physical injury; short term medical treatment may be indicated.

c. Severe Spouse Abuse

(1) Any injury during pregnancy.

(2) Spouse choked or strangled.

(3) Spouse severely beaten.

(4) Spouse threatened with a knife or gun.

(5) Spouse cut with knife or shot at.

(6) Battered spouse syndrome.

(7) Spouse threatened or hit with a motor vehicle.

(8) Spouse sexually abused.

(9) Major physical injury or long term medical treatment, inpatient care, or move to alternate environment for the safety of the spouse.

(10) Spouse killed.

CHAPTER 4

PROCEDURES: STANDARD OF CARE GUIDELINES

4.1 Standard of Care Guidelines for Case Management of Spouse Abuse
4.2 Table 1: Standard of Care Guidelines for Case Management of Spouse Abuse

4.1 STANDARD OF CARE GUIDELINES FOR CASE MANAGEMENT OF SPOUSE ABUSE

a. Table I below (Table I is duplicated in Appendix A) summarizes the majority of the spouse abuse protocol. It illustrates the flow of procedures from start to finish. Included in the process is the implementation of Quality Management procedures and the Total Army Quality process (AR 5-1). The table refers to a number of appendices, which are found at the end of this manual. Each individual component of the table will be reviewed.

4.2 TABLE I: STANDARD OF CARE GUIDELINE FOR CASE MANAGEMENT OF SPOUSE ABUSE

a. The table introduces or stresses a number of assessment and treatment elements that have not been addressed or clearly articulated in regulations or pamphlets regarding spouse abuse. These elements include:

(1) Assessment drives treatment. Treatment should be based upon the needs of the individual client as determined by the clinical assessment process. The availability or access to specific psycho educational and clinical treatment resources should not be the determining factor in selecting a treatment plan. Assessment is absolutely critical to determining the level of abuse, developing a treatment plan, implementing treatment, and ensuring a successful outcome.

(2) The l996 Comprehensive Accreditation Manual for Hospital developed by the Joint Commission on Accreditation of Healthcare Organizations requires that possible victims of abuse

are identified and assessed using objective criteria developed by the hospital (Assessment of Patients, Standard 1.8). The criteria must address physical assault, rape or other sexual molestation, domestic abuse, and abuse or neglect of elders and children. The evaluation process or assessment must prevent any action or question that could create false memories of abuse in the individual being assessed.

(3) The case manager is ultimately responsible for the formulation of the treatment plan, length of treatment, and the sequencing of treatment for the identified client(s). Sequencing involves moving from one treatment modality to another modality for the treatment of a specific identified problem. This may involve starting with education on individual therapy, then moving to group therapy and finally to marital therapy.

(4) The case management model forms the foundation for intervention for the clinical portion of the spouse abuse program.

(5) Spouse abuse assessment involves ruling out child abuse to include children who witness domestic violence. Current literature has identified the need to assess children who may have witnessed domestic violence and therefore may need treatment intervention (see Appendix L).

(6) Treatment is evaluated for efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, and efficiency. Administrative and clinical program components must be evaluated for continuous improvement by an established and on-going Quality Management program or process. Established programs and processes include Sociometrics evaluation, Family Advocacy Program Standards and Self-Assessment Tool (DOD 6400.1-M), Implementation of the Total Army Quality (TAQ) methodology to achieve continuous improvements (AR 5-l), Joint Commission on Accreditation of Healthcare Organizations standards, Malcolm Baldrige National Quality Award criteria, and Quality Management recommendations and procedures developed locally.

(7) Five levels of abuse (degrees of severity) are employed to assist with designing a treatment plan and making recommendations to command (see Appendix I).

(8) During the formulation of the treatment plan, all psycho educational and treatment options must be considered. Psycho educational programs include extensive non therapy programs such as the victim advocate program (see Appendix M), the New Parents Support Program, Parent Effectiveness Training, Communication Building, Financial Management, Conflict Management, Pre-marital counseling, Alcohol Abuse Prevention and Children Who Witness Violence.

b. Table I is not totally inclusive of all spouse abuse functions identified in AR 608-l8. For example, the time required to perform certain functions is not identified.

DESCRIPTION OF EAC COMPONENT OF THE STANDARD OF CARE GUIDELINES FOR THE MANAGEMENT OF SPOUSE ABUSE

5.1 Nine Components
5.2 Case Management
5.3 Incident Referral
5.4 Assessment
5.5 Formulation of Problem/Treat. Plan
5.6 CRC Case Presentation
5.7 Treatment
5.8 CRC Follow-up Case Presentation
5.9 Follow-up After Case Closure
5.10 Quality Management Procedures

5.1 NINE COMPONENTS:

a. The nine components of the standard of care guidelines for spouse abuse are identified below.

(1) Case Management Model.

(2) Incident Referral.

(3) Assessment.

(4) Formulation of Problem and Treatment Plan.

(5) CRC Case Presentation.

(6) Treatment.

(7) CRC Follow-up Case Presentation.

(8) Follow-up After Case Closure.

(9) Quality Management Procedures.

b. Each component will be discussed in detail in the following.

5.2 CASE MANAGEMENT MODEL-PRACTICE FUNCTIONS (See Appendix B):

a. The clinical case management model identifies generic direct practice functions. The model provides the foundation for the clinical delivery of social or behavioral services. Case management addressed the many needs of service delivery, such as: information gathering, assessment functions, problem identification, identification and coordination of services, treatment, comprehensive delivery of services to a vulnerable population, monitoring of services, and outcome evaluation.

b. The eight elements of the case management model are described below. A chart is provided (see Appendix B) with each element and a description of the intent, function, and skill components of each element.

(1) Interviewing and interviewing skills. Interviewing is the process which captures pertinent information from individuals. There are a number of interviewing skills which contribute to successful interviewing or data collection.

(2) Clinical assessment. The assessment process structures the collection of predetermined information which is essential for problem identification, safety plans, identifying levels of abuse, treatment formulation, predicting treatment outcome, treatment delivery, and follow-up. The assessment instrument is utilized for the collection of information to ensure that only the required information is collected to meet the objective of the assessment.

(3) Formulation of the problem. The collected predetermined information is brought together to form a case summary which addresses etiology, diagnosis, prognosis, and treatment needs. The individual bits of information are tied together by clinical theory.

(4) Problem list. Each identified problem is documented. The problem list should include the identification of all problems, contributing secondary problems, the level of spouse abuse (level 1 to 5, see Appendix I), and the severity of the problems.

(5) Treatment plan. All identified problems will be on the treatment plan. A comprehensive treatment plan is developed for each identified problem. Each treatment plan should be congruent with the identified problem (the treatment plan treats the identified problem); the length of treatment, and how the treatment will be delivered or the phasing of treatment should be identified. For example, one identified problem may be treated or sequenced first with a 4 week class in human development, then with 16 weeks of individual therapy, then with 12 weeks of couple therapy, and finally with 10 weeks of family therapy for a total of 42 weeks of treatment. Justification must be provided for all identified problems that will be deferred.

(6) Treatment. The treatment plan is implemented as designed and treatment is provided. Treatment is directed by the treatment plan. The treatment plan may be modified based upon recurring assessments. Treatment may also include contact by telephone to assess progress of the Treatment Plan or to determine recurring instances.

(7) Evaluation. The efficacy, appropriateness, availability, timeliness, effectiveness, continuity, and efficiency of the treatment process, as well as the safety of and the respect and caring for the victim and offender, are all evaluated during the entire evaluation and treatment process.

(8) Follow-up. After the case is closed, follow-up studies may be conducted to determine the short-term and long-term effectiveness of the treatment program. These follow-up studies are often referred to as outcome studies.

5.3 INCIDENT REFERRAL:

a. Determine if victim is an eligible military medical beneficiary.

b. Determine if the referral qualifies as a Family Advocacy case.

c. Ensure that all reports of spouse abuse are assessed. Case determination cannot be made until an assessment is completed.

d. Complete Family Advocacy Intake MEDCOM Form 650-R (see Appendix C).

e. A Level II provider performs initial risk/safety assessment. Use the MEDCOM Form 665-R for this function (see Appendix D). Risk assessment pertains to two components. First to a case manager making a decision, and second to a specific instrument used for the decision making process. The case manager must be highly competent and skilled to make risk assessment determinations. The risk assessment is made by a case manager using an assessment instrument. The assessment instrument does not make a determination of risk. There are four basic approaches to risk assessment instruments, which are:

(1) Matrix approach which utilizes tables composed of factors to rate severity or risk of abuse. Each factor is given a risk score.

(2) Empirical predictor approach which identifies a set of risk factors which are predictive of abuse.

(3) Family assessment approach consists of scales to assess abuse.

(4) Child at-risk approach utilizes an ecological model and is centered around specific fields. These fields traditionally include child, parent, family, maltreatment, and intervention. Questions and rating scales are used to identify risk influences.

f. Ensure the safety of the victim/family and offender.

g. Make appropriate notifications (ER, MP, CID, CO, State, etc).

5.4 ASSESSMENT:

a. Review all available/existing information from collateral organizations.

b. Interview all individuals involved in the incident.

c. Conduct social history (See Family Advocacy Program Social History MEDCOM Form 647-R-E, Appendix E).

d. Conduct psychosocial assessment (The psychosocial assessment may incorporate a social history.) (see Appendix F for examples of psychosocial assessments).

e. Conduct mental status examination; evaluate for suicide, homicide, ETOH/drugs, and weapons. Make appropriate referrals as necessary. The psychosocial assessment may consists a mental status examination.

f. Conduct Risk Assessment (MEDCOM Form 665-R, Appendix D).

g. Review safety/protection plan with victim. (See Appendix G for examples of safety/protection plans.)

h. Request that a medical evaluation be conducted. Use MEDCOM Protocol For The Initial Identification, Assessment, and Disposition of Spouse Abuse (see Appendix H).

i. Request physician review the victim(s) medical record for history of abuse.

j. Query the Central Registry for previously substantiated abuse.

k. Evaluate history of head injury for both victim and offender. Some research suggests that a history of a closed head injury may be related to violent behavior.

l. Assessment of psychological or physical harm of any child or children residing in the home. Conduct assessment for children who witness domestic violence (see Appendix L).

m. Determine the level of abuse, from level 1 to 5, using the Spouse Abuse Matrix (see Appendix I). Chapter 5 discusses the Spouse abuse Matrix.

n. Complete problem list.

o. Provide the victim and the offender a completed and signed copy of the CRC review process; retain a copy for the filing (See Appendix J).

5.5 FORMULATION OF PROBLEM AND TREATMENT PLAN:

a. Formulate etiology, diagnosis, prognosis, and treatment plan.

b. Intervention is problem based. Each identified problem is adequately defined. This is essential since a plan is designed to address each problem statement.

c. In the Treatment plan, there is a plan for each problem statement.

d. Treatment plan based on problem formulation, problem list, identified level of abuse (level 1 to 5, see appendix I), and treatment planning guide (See appendix K and chapter 7).

5.6 CRC CASE PRESENTATION:

a. All case presentations are in the same standardized format. See 608-l8, appendix Section IX, figure B-l, entitled: "Family Advocacy Initial Case Presentation Format."

b. Company commander or civilian supervisor is invited, in writing, to attend CRC case presentation.

c. CRC case presentation.

d. CRC approves/augments recommended treatment plan if case is substantiated.

e. Prepare and forward DA Form 2486 to PASBA.

f. CRC approves treatment for "at-risk" unsubstantiated cases. Per AR 608-18, the Family Advocacy Program will provide services to "at-risk" families who are vulnerable to the kinds of stresses that can lead to abuse. The "at-risk" cases are preventive cases.

5.7 TREATMENT:

a. Implement treatment plan.

b. Case manager actively monitors the case from inception to closure.

c. Evaluate treatment outcome to include reevaluation of risk assessment.

d. Recommend case closure to the CRC. Only the CRC can close a case.

5.8 CRC FOLLOW-UP CASE PRESENTATION:

a. Standardized case review within 90 days (See AR 608-18, appendix B, Section IX, figure B-2 entitled: "Family Advocacy Review Case Presentation Format").

b. CRC approval for case closure.

5.9 FOLLOW-UP AFTER CASE CLOSURE:

a. Evaluate treatment plan outcome.

b. Conduct relapse evaluation.

5.10 QUALITY MANAGEMENT PROCEDURES:

a. Implement Quality Management indicators to measure compliance and track clinical standards of care (outcome results).

b. Implement Quality Management indicators to measure and track compliance to program administrative standards (process results).

c. Implement Army Management Philosophy, dated 12 June l992, under AR 5-1 which establishes Total Army Quality (TAQ) procedures. The TAQ provides the methodology, tools, and techniques to perform the systematic analyses of organizations and work processes to achieve the requisite improvements.

d. The Joint Commission on Accreditation of Healthcare Organizations establishes standards for response to child abuse, spouse abuse, and elder abuse.

e. Utilize Family Advocacy Program Standards and Self-Assessment Tool (DOD 6400.1-M).

f. Utilize Sociometrics findings.

g. Utilization of the Malcolm Baldrige National Quality Award criteria.

CHAPTER 6

LEVELS OF ABUSE

6.1 Spouse Abuse Matrix
6.2 Incremental Progression

6.1 SPOUSE ABUSE MATRIX:

a. The Spouse Abuse Matrix (see appendix I) identifies five levels of spouse abuse. The level of abuse is identified during the assessment phase. Each level of abuse is defined and the risk for the victim is identified for each level. Each level of abuse provides guidance for:

(1) Determining the "intent" of intervention.

(2) Recommendations for "clinical intervention" or treatment planning for both the offender and victim. Treatment planning is further delineated by the Treatment Planning Guide which identifies the "type of treatment" for the offender, victim, and children. The Treatment Planning Guide is discussed in chapter 7 (see Appendix K).

(3) Command options or recommendations for intervention.

6.2 INCREMENTAL PROGRESSION:

a. Each level of abuse progresses incrementally from minor (level I) to severe, including death (level 5). The risk for the victim increases incrementally from level 1 to level 5 as does the length of treatment for both the offender and victim, except for level 5.

b. Level 5 recommends intensive treatment for the victim but departs from traditional recommendations for the offender. Level 5 recommends no Family Advocacy Program treatment for the offender. This does not preclude referrals for treatment outside of the Family Advo-

cacy Program. Command options for the offender include prosecution under the military justice system and/or civilian court system and/or separation from the service. Command options for the victim include support and compliance with CRC recommendation to the maximum extent possible.

TREATMENT PLANNING GUIDE

7.1 Treatment Guideline
7.2 Length of Treatment and Sequencing

7.1 TREATMENT GUIDELINE:

a. The Treatment Planning Guideline corresponds to levels 1 to 5 of the Spouse Abuse Matrix.

b. The Treatment Planning Guideline recommends a combination of psycho educational and treatment sessions for each level of abuse for the offender, victim, and children.

7.2 LENGTH OF TREATMENT AND SEQUENCING:

a. The identification, utilization, and length of psycho educational classes are left to the discretion of the case manager. The psycho educational classes and clinical interventions identified are not inclusive, but are only suggestive. The actual psycho educational classes and/or interventions required would be based upon the assessment.

b. Recommended number of treatment sessions for each level of abuse is provided.

NOTES

APPENDIXA: STANDARD OF CARE GUIDELINES FOR CAS MANAGEMENT

Table 1: Standard of Care Guidelines for Case Management of Spouse Abuse

Reference: Chapter 4

These standard of care guidelines for the case management of spouse abuse take the form of a check-list and include important reminders related to the case management process:

- ☑ Incident Referral
- ☑ Assessment
- ☑ Formulation of Problem and Treatment Plan
- ☑ CRC Case Presentation
- ☑ Treatment
- ☑ CRC Follow-up Case Presentation
- ☑ Follow-up After Case Closure
- ☑ Quality Management Procedures

NOTES

TABLE I: STANDARD OF CARE GUIDELINE FOR CASE MANAGEMENT OF SPOUSE ABUSE

1. CASE MANAGEMENT MODEL (See appendix B):

a. Interviewing and interviewing skills.
b. Clinical assessment.
c. Formulation of problem.
d. Problem list.
e. Treatment plan.
f. Treatment.
g. Evaluation.
h. Follow-up.

2. INCIDENT REFERRAL	**YES**	**NO**	**N/A**
a. Eligible military beneficiary.			
b. Qualifies as a FAP case.			
c. All reports of spouse abuse are assessed.			
d. Complete Family Advocacy Intake information (See Appendix C: HSC Form 650-R)			
e. Perform initial Risk/Safety assessment (Appendix D).			
f. Ensure the safety of the victim/family/offender.			
g. Make appropriate notifications (ETC/MP/CID/CO, State, etc.).			
3. ASSESSMENT			
a. Review all available/existing information from collateral organizations.			
b. Interview all individuals involved in the incident.			
c. Conduct social history (See appendix E).			
d. Conduct psychosocial assessment (Appendix F).			
e. Conduct mental status exam; evaluate for suicide, homicide, ETOH/drugs, and weapons (make appropriate referrals as required)			
f. Conduct second Risk Assessment (MEDCOM Form 665-R, appendix D).			
g. Review safety/protection plan (See appendix G).			

3. ASSESSMENT, cont.	YES	NO	N/A
h. Request medical evaluation and conduct social work five part assessment (See Appendix H).			
i. Request physician review the victim's medical record for history of abuse.			
j. Query the Central Registry for prior substantiated cases of abuse.			
k. Evaluate history of head injury (perpetrator and victim).			
l. Assessment of psychological or physical harm of any child or children residing in the home.			
m. Determine the Level of spouse abuse; from level 1 to 5 (See appendix I).			
n. Complete problem list.			
o. File signed CRC review process Information Paper (See appendix J).			
4. FORMULATION OF PROBLEM AND TREATMENT PLAN			
a. Formulate the nature of the problem.			
b. Intervention problem based: Each identified problem adequately defined.			
c. Intervention is goal based: Each element of treatment plan addresses each identified problem.			
d. Develop treatment plan based on problem formulation, problem list, identified Level of abuse 1 to 5 (See Appendix I and Chapter 6), and treatment planning guide (See Appendix K and Chapter 7).			
5. CRC CASE PRESENTATION			
a. Standardized presentation (See AR 608-18, Appendix Section IX, fig. B-1).			
b. Company commander or civilian supervisor invited in writing to attend CRC case presentation.			
c. CRC case presentation.			
d. CRC approves/augments treatment plan.			
e. Prepare and forward DA Form 2486 to PASBA.			
f. CRC approves treatment for "at-risk" unsubstantiated cases.			

6. TREATMENT	YES	NO	N/A
a. Implement treatment plan.			
b. The case manager actively monitors the case from inception to closure.			
c. Evaluate treatment outcome to include Risk Assessment.			
d. Recommend to the CRC case closure.			
7. CRC FOLLOW-UP CASE PRESENTATION			
a. Standardized case review within 90 days (AR 608-18, appendix B, Section IX, figure B-2).			
b. CRC approval for case closure.			
8. FOLLOW-UP AFTER CASE CLOSURE			
a. Evaluate treatment plan efficiency.			
b. Relapse evaluation.			
9. QUALITY MANAGEMENT PROCEDURES			
a. Utilize QM indicators to measure compliance to clinical standards of care (outcome).			
b. Utilize QM indicators to measure compliance to administrative standards of care (process). c. Utilize Total Army Quality (TAQ) methodology to achieve continuous improvements (AR 5-1).			
d. Comply to JCAHO standards regarding child and spouse abuse.			
e. Utilize Family Advocacy Program Standards and Self-Assessment Tool (DOD 6400.1-M).			
f. Utilize Sociometrics findings.			
g. Utilize Malcolm Baldrige National Quality Award criteria.			

NOTES

APPENDIX B: CASE MANAGEMENT MODEL

Case Management Model Chart

Reference: Chapter 5.2 b.

The Clinical Case Management Model addresses patient outreach and identification, individual and family assessment, problems, treatment planning, resource identification, linking of patients with services, advocacy, implementation of the treatment plan, and monitoring of treatment and evaluation. The following chart describes the intent, function, and components of:

- ☑ Interviewing and Interviewing Skills
- ☑ Clinical Assessment (Types)
- ☑ Formulation of the Problem
- ☑ Problem List
- ☑ Treatment Plan
- ☑ Treatment
- ☑ Evaluation
- ☑ Follow-up

	INTERVIEWING & INTERVIEWING SKILLS	CLINICAL ASSESSMENT (TYPES)	FORMULATION OF THE PROBLEM	PROBLEM LIST
INTENT	These skills are essential for data collection and treatment intervention.	Data "bits" are essential for problem etiology, prognosis, and planning.	Utilization of assessment "bits" and problem list to combine or integrate information into a comprehensive problem statement and contributing risk factors.	Identification of problems which will be used in problem formulation and treatment strategy.
COMPONENTS	a. Use of combined skills to collect required clinical assessment data. b. Use of rapport skills to establish therapeutic relationships. c. Use of combined skills in provision of treatment.	a. Collect data to identify nature and cause of problems. b. Differentiation of spouse abuse from level 1 to level 5. c. Diagnostic determination. d. Intervention data and treatment phasing data.	a. Conceptualize the nature of the presenting problem(s). b. Provide clarification of multiple "bits" of information and/or data.	a. Identification and statement of each problem. b. Identification and statement of contributing secondary problems. c. Identification of level of spouse abuse from 1 to 5. d. Identification of various problem orders, such as: severity, phasing of treatment, and length of treatment. e. Identification of needed referrals or adjunct services.
FUNCTION	a. Interview control. b. Calibration. c. Validation. d. Congruency. e. Arousal control. f. Male/Female language. g. Metaphor construction. h. Mythology interpretation. i. Frames and language. j. Question construction. k. Disassociation procedures.	a. Crisis intervention. b. Risk assessment. c. Psychosocial assessment. d. Mental Status Exam. e. Social interaction. f. Medical assessment. g. Personality assessment. h. Vocational assessment. i. Stress Management. j. Developmental assessment. k. Motivational solution states.	a. Knowledge of professional literature. b. Knowledge of theories. c. Review all assessment data. d. Knowledge of specific treatment modalities, such as educational, individual, couple, marital, and family. e. Knowledge of child, adult, and family development.	None

TREATMENT PLAN	TREATMENT	EVALUATION	FOLLOW-UP
INTENT			
Development of a comprehensive treatment plan for each identified problem on the problem list.	Provision of appropriate treatment for identified problems.	Measurement of treatment progress and efficiency of a treatment regimen throughout the duration of the treatment process.	Measurement of the effectiveness of the treatment regimen after program completion.
COMPONENTS			
a. To guide the clinician throughout the duration of treatment. b. Adds structure to the treatment process. c. Might be predictive of the course of treatment. d. Helps guide the assignment of "homework."	a. To provide the service that will help the client.	a. To assess the degree of treatment success at the close of treatment.	a. To assess continuation of a violence free relationship.
FUNCTION			
a. Each identified problem has a corresponding treatment plan. b. Treatment plan is congruent with the identified problem(s). c. Length of treatment identified for each problem. d. Treatment phasing identified for each problem. Example for one problem: Human development—4 weeks; Individual therapy—16 weeks; Couple therapy—12 weeks; Family therapy—10 weeks.	a. Knowledge of therapies. b. Knowledge of purpose and limitation of each therapeutic modality. c. Qualified to provide treatment.	**MEASUREMENT TOOLS**: a. Statistical evaluation. b Milestones. c. Level of treatment change. d. Goals achieved. e. Contract compliance. f. Symptom reduction. g. Termination of specific behaviors. h. Achieved desired state. i. Resolved problem state. j. Emotional state in control. k. Attitudinal changes.	**MEASUREMENT TOOLS**: a. Written questionnaire. b. Telephone inquiries of both victims and perpetrators. c. Command consultation. d. Relapse evaluation.

NOTES

APPENDIX C: FAMILY ADVOCACY INTAKE

MEDCOM FORM 650-R

Reference: Chapter 5.3 d.

This section includes a copy of the MEDCOM Form 650-R.

NOTES

FAMILY ADVOCACY INTAKE

Today's Date _____

(Privacy act statement contained in case file folder. For use of this form see MEDCOM Pam 608-1.)

Sponsor's Name _____ Age _____ DOB _____
(Last name, First name, Middle Initial)

Grade _____ Social Security Number _____ Time in Service _____

Branch of Service *(Circle one)* USA USAF USN USMC USCG RESERVES OTHER

Status: ACTIVE DUTY RETIRED FAMILY MEMBER OTHER

Unit _____

Duty Phone _____ Commander's Name and Phone _____

Home Address _____

Home Phone _____ ETS Date _____ PCS Date _____ DEROS Date _____

Are you pending deployment? Yes No Race/Ethnic Group _____

Are you enrolled in PRP? Yes No

Spouse's Name _____ Age _____ DOB _____
(Last name, First name, Middle Initial)

Grade _____ Social Security Number _____ Time in Service _____

Branch of Service *(Circle one)* USA USAF USN USMC USCG RESERVES OTHER

Status: ACTIVE DUTY RETIRED FAMILY MEMBER OTHER

Unit _____

Work/Duty Phone _____ Commander's Name and Phone _____

Home Address _____

Home Phone _____ ETS Date _____ PCS Date _____ DEROS Date _____

Are you pending deployment? Yes No Race/Ethnic Group _____

Are you enrolled in PRP? Yes No

Children:

Name *(Last name, First name, Middle Initial)*	SSN	Sex	AGE & DOB	Race	School Grade	Living at Home
Child 1 _____	_____	____	_____	_____	_____	YES NO
Child 2 _____	_____	____	_____	_____	_____	YES NO
Child 3 _____	_____	____	_____	_____	_____	YES NO
Child 4 _____	_____	____	_____	_____	_____	YES NO
Child 5 _____	_____	____	_____	_____	_____	YES NO

(Use additional sheet, if necessary)

List others Living in the home *(Aunt, Grandfather, etc)* _____

_____

FAMILY ADVOCACY INTAKE (CONTINUED)

CURRENT PROBLEMS

	YES	NO	N/A
Child Abuse			
Spouse Abuse			
Financial			
Unit (Job)			
Child Care			
Recent Move			
Pending Move			
Lonliness/Isolation			
Pending Discharge			
Legal			
Physical Medical Problems			
Mental Health Problems			
Family Member Illness			

	YES	NO	N/A
Family Disagreements			
Religious Differences			
Racial/Cultural Differences			
Death in the Family			
Infidelity			
Housing/Neighborhood Issues			
Alcohol/Drugs			
Sexual Problems			
Child Rearing Methods			
Suicide Attempts			
Criminal Problems			
EFMP			
UCMJ/Disciplinary Actions			

Experience with counseling, if any:

	YES	NO
Chaplains		
Alcohol/Drug		
School counselors		
Marriage and family counseling		

	YES	NO
Social Work Service		
Community Mental Health		
Court Mandated counseling		
Child Protective Services		

Marital Information:

What is your marital status? ( ) Single ( ) Divorced ( ) Widow/Widower ( ) Separated ( ) Married

Length of marriage _____yrs Number of previous marriages _____

Is spouse residing with you? YES NO

Please list any medications that you are currently taking:

_____

_____

_____

Briefly describe why you are here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX D: RISK/SAFETY ASSESSMENT

MEDCOM FORM 665-R

Reference: Chapter 5.3 e.
Chapter 5.4 f.

This section includes a copy of the MEDCOM Form 665-R.

NOTES

Spouse Abuse Risk Assessment

For use of this form see MEDCOM Pam 608-1

RISK FACTORS	LOW (L)	MODERATE (M)	HIGH (H)	CODE
History of Abuse/FAP history	No prior reports or injuries	Prior minor injuries*	Subsequent incident with major injuries*	
Substance use	None	Some use, non-contributing factor	Significant use, contributing factor	
Extent of physical injury	No medical treatment needed	Minor physical injury/treatment*	Major physical injury* or hospitalization. Injury during pregnancy	
Use of weapons	None	Weapons available, not used	Weapon used or threat to use	
Emotional maltreatment	None/infrequent	Frequent/chronic	Threats of death or serious injury/stalking	
Location of children	Known/no risk	Known, minimal risk	Unknown or with perpetrator	
Forced sex	No evidence or allegation	Allegation with no evidence	Evidence of forced sex	
Family stressors	None	Minimal	Multiple	
Location of perpetrator	Known, no access to victim	Known, access to victim	Unknown or "Atlarge"	
Assault history of perpetrator	None	Infrequent/ occasional episodes	Frequent/chronic episodes	
Fear of perpetrator	None	Minimal	Significant	
Safety plan	Appropriate	Vague	None	

COMMENTS: _____

_____

_____

_____

_____

_____

DATE: _____

PT NAME: _____

SSN: _____

WORKER: _____

RECOMMENDATIONS:

This form has been reviewed by me and I understand the risks and recommendations

SIGNATURE: _____ DATE: _____

INSTRUCTIONS

1. Use of this form in instances of spouse abuse assessment and consultation with other professionals, will aid the interviewer in determining the immediate safety of the victims. This determination should be the basis of developing plans and options for the victim and any dependent. The safety of the spouse and any children should always be the prime consideration. The Command must always be notified.

2. In making a determination and plans, consider the following:

a. Any "H" rating must be thoroughly evaluated to determine whether or not the spouse may safely return home. If the spouse can not return home, other appropriate options (e.g., shelter, confinement of the alleged perpetrator, etc.) must be considered.

b. A majority of "M" ratings require additional assessment prior to making a disposition.

c. A majority of "L" ratings indicate there is little or no risk of maltreatment.

d. Regardless of the determined level of risk (coding), a nonmilitary victim has the legal right to refuse any recommendations.

e. Advise the victim of the determined risk and recommendations. The victim needs to indicate by their signature that they have been advised of the risks and treatment recommendations.

f. Items indicated by an "*" are defined in AR 608-18 and local SOPs.

3. Use the 'Comments' section to include additional information that contributed to making a determination of risk.

4. Discuss any questions of interpretation of this Risk Assessment tool with the Chief, Social Work Service or immediate supervisor.

APPENDIX E: SOCIAL HISTORY [EXAMPLES]

MEDCOM FORM 647-R-E (MCHO) OCT 94

Reference: Chapter 5.4 c.

The following information, as a minimum, must be considered in the development of the social history during the intake/assessment process:

- ☑ Review and discuss intake forms with client(s).
- ☑ Identify the client(s) definition of the presenting problem.
- ☑ Identify and list current problem(s).
- ☑ Inquire about any sexual history/Incest/Rape (recent/past).
- ☑ Past or present history of violence - family and other.
- ☑ Current parent/child relationship(s).
- ☑ Use/abuse of substances (alcohol and drugs).
- ☑ Previous involvement with FAP/CPS.
- ☑ Check the PASBA Central Registry.
- ☑ History of personal or family mental illness:
  - Past and present.
  - Homicidal/suicidal ideation, threats, attempts, etc.
  - Use of psychotropic medication(s).
- ☑ Mental Status Examination
- ☑ Develop a problem list.
- ☑ Outline a treatment plan.

NOTES

FAMILY ADVOCACY PROGRAM (FAP) SOCIAL HISTORY
(See Privacy Act Statement - FAP Case File#____, TAB L)

Date:_____

Section I. Identifying Data:

A. Name of Sponsor _____

Social Security Number _____

Home Address _____

Home Phone Number _____

Duty Phone Number _____

Commander's Name _____

Level of Education _____

B. Name of Spouse _____

Social Security Number _____

Home Address _____

Home Phone Number _____

Work Phone Number _____

Employer's Name _____

Level of Education _____

C. The Presenting Problem as Identified by Each:

1. Husband: _____

2. Wife: _____

D. Referral Source: _____

E. Problem (Event) Identified by Referral Source_____

II. Current Problems:

	YES	NO
Financial	____	____
Unit (Job)	____	____
Child Care	____	____
Recent Move	____	____
Pending Move	____	____
Loneliness/Isolation	____	____
Pending Discharge	____	____
Legal	____	____
Medical	____	____
Family Disagreements	____	____
Religious Differences	____	____
Racial/Cultural Differences	____	____
Deaths in the Family	____	____
Infidelity	____	____

Explain any yes answer: _____

_____

_____

_____

_____

_____

III. History of Violence in the Family, if any:

	YES	NO
1. Did you witness abuse as a child?	____	____
2. Were you abused as a child?	____	____
3. If you were abused, how?		
a. Physically	____	____
b. Sexually	____	____
c. Emotionally	____	____
d. Needs neglected	____	____

4. Have you had any previous involvement with the Family Advocacy Program or the Child Protective Services?

Explain any yes answer: _____

IV. Substance Use/Abuse:

	YES	NO
A. In the current family does anyone use/abuse alcohol/drugs?	____	____

Explain any yes answer: _____

	YES	NO
B. In the families of origin did anyone use/abuse alcohol/drugs?	____	____

Explain any yes answer: _____

V. History of Mental Illness (Include Suicide and Homicide Attempts):

VI. A Description of the Family of Origin (Include how discipline/punishment was handled. Also include their location and their contacts with our client's family):

Husband: _____

Wife: _____

VII. Past Marriages (reasons why they ended: divorce, why?; death, how?):

Husband: _____

Wife: _____

VIII. Description of the Current Family:

A. Husband_____ Date of Birth_____

Wife_____ Date of Birth_____

Date of Marriage_____

Length of Time Known Prior to Marriage_____

How they met_____

Current relationships (define how listed members relate. Include relationships of parents to each other and to <u>each</u> child in the family. Tell who is "in charge" and how):

B. Children	DOB	School

C. Answer the following questions:

	YES	NO
1. Were any of these children unplanned/unwanted?		
2. Do any of these children have medical problems?		
3. Are any of these children difficult or exceptional in any way?		
4. Are there any present special problems?		
5. Did marital relationship change after a child's birth?		

Explain any yes answer:

D. List any other persons in the household. Define their relationship and tell why they are in the household and how they affect it.

E. How is discipline administered and by whom?

F. How are problems solved?

G. How are emotions/feelings handled in the family? (Which emotions are expressed, by whom, when?)

H. What does each partner like/dislike about marriage?

I. What does each parent like/dislike about parenting?

J. Who does the family rely on for help with problems?

K. How is spare time spent?

L. Experience with counseling, if any:

	YES	NO
Chaplains	____	____
Alcohol/Drug	____	____
School counselors	____	____
Marriage and family counseling	____	____
Social work service	____	____
Community mental health	____	____
Court mandated counseling	____	____

Explain any yes answer:

_____
_____
_____
_____
_____
_____

IX. Areas of strength (Include what the clients believe and what you see, note the distinction.)

_____
_____
_____
_____
_____
_____

X. Geneogram (optional)

XI. Social worker description of each partner's affect (include how they present themselves, their cognitive functioning, their professed and displayed value system, their dependency roles, their ability to participate with peers, their willingness to participate in treatment:

Husband:_____

_____

_____

_____

_____

_____

Wife:_____

_____

_____

_____

_____

_____

_____
Signature of individual completing form

APPENDIX F: PSYCHOSOCIAL ASSESSMENT

- FORM DA 4700 (EAMC OP 540, 1 NOV 94)
- DOMESTIC VIOLENCE ASSESSMENT
- ASSESSMENT SCALE
- DOMESTIC VIOLENCE INITIAL ASSESSMENT
- SI: PART 1 & PART 2
- AI: PART 1 & PART 2

Reference: Chapter 5.4 d.

This section includes psychosocial assessments.

NOTES

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*
FAMILY ADVOCACY PSYCHOSOCIAL ASSESSMENT SHEET	

SEX: Male/Female STATUS: Spouse or (NS/ND/SS/SD/AS/AD) Natural/Step/Adopted

AGE:_____

SPONSOR'S NAME:_____ RANK:_____

SSN:_____ ACTIVE DUTY:_____ RETIRED:_____ MILITARY

BRANCH OF SERVICE:_____ UNIT:_____

_____

Referral Source:_____

Reason for Referral:_____

_____

History of Presenting Problem:_____

_____

_____

_____

_____

_____

I. FAMILY/RELIGIOUS HISTORY:

Patient's Place of Birth:_____

Mother's Name:_____ Father's Name:_____

Parents Relationship:_____

Patient's Relationship w/each Parent:_____

Parents use of Discipline:_____

Experiences of Abuse/Neglect (Yes/No) If yes, explain_____

_____

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

*U.S. GPO: 1993-300-727/90365

_____

_____

If yes, how have you protected yourself?_____

Pregnancy History and Results:_____

_____

_____

Child/Children Relationship with Mother/Father:_____

_____

_____

Total Number of Children:_____1st Marriage_____2nd Marriage

Religious Preference:_____

Part Religion plays/played in Life:_____

_____

II. MEDICAL/PSYCHIATRIC HISTORY:

History of Psychiatric, Substance and Medical Illnesses:_____

_____

_____

List illnesses (Usual, Childhood, Major or Present):_____

_____

_____

Childhood diseases or developmental delays:_____

_____

Surgeries:_____

_____

Medications:_____

_____

III. DRUG/ALCOHOL HISTORY:

Use of Alcohol: In the Past? (Yes/No) Type:_____

Frequency:_____ Quantity:_____

At Present? (Yes/No) Type:_____

Frequency:_____ Quantity:_____

Use of Drugs: In the Past? (Yes/No) Type:_____

Frequency:_____ Quantity:_____

At Present? (Yes/No) Type:_____

Frequency:_____ Quantity:_____

Any significant changes in usage pattern? (Yes/No) If yes, explain_____

_____

Age began using Drugs?_____ Alcohol?_____

Any Blackouts? Yes/No Flashbacks? Yes/No DWI's? Yes/No

Any treatment received for drug/alcohol usage? (Yes/No) If yes, please list_____

_____

Do you consider your drug/alcohol usage a problem? (Yes/No)

If yes, explain_____

IV. SCHOOL HISTORY:

Grade completed:_____ College_____ Technical_____

Describe School Performance and Behavior:_____

_____

_____

_____

Describe Relationships with Teachers and Peers:_____

_____

_____

Describe Maintenance of Friendships which began in School:_____

_____

_____

V. EMPLOYMENT HISTORY:

List last (3) Job Positions held (current to latest):

1)_____ 2)_____ 3)_____

Describe Performance on Jobs: 1)_____

_____

2)_____

_____

3)_____

Describe Relationships with Co-Workers/Employers:_____

_____

_____

_____

VI. MARITAL HISTORY:

Marital Status: _____Single _____Married _____Divorced
_____Separated _____Widow/Widower

Length of Marriage:_____Years _____Months

Number of Previous Marriages:_____

Is Spouse residing with you? _____Yes _____No

If **No** due to divorce or separation, discuss nature of problem in relationship:_____

_____

VII. LEGAL PROBLEMS:

List legal difficulties resulting in contact with law enforcement:_____

_____

_____

Dates of jail sentences served:_____

_____

List any present legal concerns:_____

_____

VIII. HOBBIES/SKILLS/INTEREST:

List hobbies enjoy doing:_____

_____

List any specialized skills:_____

_____

List hobbies/special skills that are of interest to you:_____

_____

IX. SUMMARY/RECOMMENDATIONS: **(FOR OFFICE USE ONLY)**

Client's Mental Status:_____

Suicidal/Homicidal Ideations: (Yes/No) If yes, explain_____

_____

_____

_____

Describe how client relates to session:_____

_____

_____

_____

Client’s strengths and problems:_____

_____

_____

_____

Recommendations:_____

_____

_____

_____

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	DOMESTIC VIOLENCE ASSESSMENT
INTRODUCTION	1st SGT POLICE INVOLVEMENT
	CHARGES PENDING COURT DATE
MARITAL HISTORY	DATE OF MARRIAGE # OF CHILDREN/AGES
	DATING BEHAVIOR
	EXPECTATIONS OF RELATIONSHIP
	MAJOR PROBLEMS & WAYS CONFLICTS WERE SOLVED
POWER/CONTROL ISSUES	ISOLATION
	FINANCES
	MALE PRIVILEGE (include housework/parenting)

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:	

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	USE OF CHILDREN
	ANGER/INTIMIDATION (eg destroying property)
	EMOTIONAL/VERBAL
	THREATS
	SEXUAL
	PHYSICAL ABUSE: INDICATE FREQUENCY
	HIM HER HIM HER
	SLAPPING PUSHING
	PUNCHING CHOKING
	KICKING PULLING HAIR
	RESTRAINING OTHER
	WEAPONS: In House? Used during incident(s)?
	DESCRIBE FIRST EPISODE (INC. DATE)
	DESCRIBE WORST EPISODE

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	USE OF SHELTER/HOTEL/FAMILY/FRIENDS
	INJURIES
	MEDICAL ATTENTION
	NATURE OF SITUATION WHICH PRECIPITATES VIOLENCE (alcohol involvement?)
	INTENT/GOAL
	FEELING AT TIME OF VIOLENCE
	EFFECTS OF VIOLENCE ON:
	PERPETRATOR -
	VICTIM -
	OTHER -
	CURRENT STATUS OF RELATIONSHIP
	VIOLENCE IN PREVIOUS RELATIONSHIPS (Inc. fighting in school, bars)

PATIENT'S IDENTIFICATION *(Use this space for Mechanical imprint)*

RECORDS MAINTAINED AT:	

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
FAMILY HISTORY	RAISED BY SIBLINGS
(of respondent)	PLACE IN FAMILY
	HOW PARENTS RESOLVED CONFLICTS (violence?)
	DISCIPLINE
	EMOTIONAL ABUSE
	PHYSICAL ABUSE
	SEXUAL ABUSE
	FAMILY HISTORY OF SUBSTANCE ABUSE
	FAMILY HISTORY OF MENTAL ILLNESS
INDIVIDUAL'S HISTORY	MENTAL HEALTH HISTORY
	FAMILY ADVOCACY HISTORY
	MARITAL COUNSELING
	CURRENT SUBSTANCE USE
	PREVIOUS ARRESTS

ASSESSMENT SCALE

Name_____ Case #_____ Date_____

Current Battery _____intimate _____non-intimate
_____family/household member
_____stranger

	Part 1	Part 2		Part 1	Part 2
Alcohol Scale	_____	_____	Socialization Scale	_____	_____
DIS Depression Scale	_____		Beck Depression Score		_____

---

support system? _____ separated from family? _____

military/combat experience? _____ weapons in house? _____

employment history? _____ stable _____ erratic
_____ unemployed (for _____ months/years)

Police Report?_____ Rap Sheet?_____ Victim's Report?_____

History of violence including violence in family of origin (include synopsis of criminal history)

_____
_____
_____
_____
_____

Interviewer's Comments (Clinical judgment):

_____
_____
_____
_____

recommend CD eval _____ recommend psych eval _____

ASSESSMENT

Intimate		Non-intimate	
high risk	_____	high risk	_____
medium risk	_____	medium risk	_____
low risk	_____	low risk	_____

DOMESTIC VIOLENCE INITIAL ASSESSMENT

Date: _____ Interviewer:_____ Case #: _____

In a domestic violence program before? yes _____ no _____

If yes: which program_____

when _____ length of program_____

completed yes _____ no _____

Name: _____ Sex _____
(last) (first) (middle)
Address:_____ City: _____ State: _____

Zip: _____ Home Phone:_____ SS#:_____

Age: _____ DOB:_____

Race: Black _____ White_____ Asian _____ American Indian _____Other_____

Hispanic? yes _____ no _____ Nationality: _____

With whom are you living?_____

Are you separated from your family?_____

Do you see your children?_____

If employed, Occupation:_____ Work ph_____

How long have you worked at this job? _____

How long did you hold last job? _____

What is the longest period you have worked at one job? _____

If unemployed, how long since last employment?_____

What is the highest grade you completed in school?_____

Have you been in the military? _____ in combat? _____

Length of service _____ Type of discharge _____

Keep weapons in the house? _____ How many? _____

Current health problems? _____

Current medications? _____

Current physician/therapist? _____

Emergency contact:_____

Victim's Name:_____

Address:_____City:_____State:_____

Zip:_____ Home Ph:_____Age: _____ DOB:_____

Race: Black_____ White_____ Asian_____ American Indian_____ Other_____

Hispanic? yes_____ no_____ Nationality:_____

Client's relationship to victim:_____

yrs in relationship:_____ # years married:_____

children in home _____ # children biological _____

Employed: yes_____ no_____ Work Phone:_____

What is highest grade victim completed:_____

Victim Advocate/Counselor involved? yes _____ no _____

Who? Spring shelter ____ Spring OR ____ SAO/VA ____ Other _____

LAW ENFORCEMENT INVOLVEMENT: TPD_____ HCSO_____ PCPD_____
TTPD_____ Other_____

Date of arrest_____ Police Report? _____ Rap Sheet? _____

Charges: felony_____ misdemeanor_____

COURT ACTION:

Judge:_____Court date:_____

Plea: Guilty_____ Not Guilty _____ No Contest _____

Disposition: Guilty _____ Not Guilty _____ No contest _____ Contin._____

Probation Officer:_____Phone:_____

HRS Worker:_____Phone:_____

Jail days served:_____ Fine paid: $_____ Term probation:_____mos

Conditions: Treatment_____ CD eval_____ Psych eval_____

Current Injunction for protection? yes_____ no_____

Date Issued:_____length_____

Conditions: FVIP_____ CD eval_____ Supervised Visitation_____
No Contact_____ Other_____

Mutual Injunction? yes_____ no_____

HISTORY OF ABUSE

	yes	no
Have you ever been to counseling for anger/abuse?	_____	_____
Have you ever had a chemical dependency evaluation?	_____	_____
Have you ever been to chemical dependency treatment?	_____	_____

If yes, where_____ when_____

Did you complete treatment? _____ _____

What do you see as the biggest problem in your current relationship?

Brief summary of incident that got you involved with the court (include use of weapon(s))

Was there violence in previous relationships? yes _____ no _____
If yes, please explain. (weapon?)

Worst violent incident you have been involved in in an intimate relationship. (weapon?)

Did you witness physical violence between your parents growing up?
yes _____ no _____ If yes, please explain.

What would you change about the way you were brought up?

Were your parents physically abusive with you? yes _____ no _____
If yes, please describe

How do you discipline your children?_____
Have you ever had fears of hurting your children? yes _____ no _____
If yes, please explain.

Depression Inventory

I. In the past month, have you been very sad or depressed or lost interest in things you used to like? _____
Did this sadness or depression last at least two weeks? _____

(if answer is no for either question, skip to question under the double line)

II. During the time you were depressed:

_____ A. Did you lose your appetite for most of the time?
_____ B. Did you lose two pounds or more a week?
_____ C. Did you have trouble falling asleep, staying asleep or waking up too early in the morning?
_____ D. Were you tired most of the time?
_____ E. Were you restless and couldn't sit still?
_____ F. Were you less interested in sex than usual?
_____ G. Did you feel worthless or sinful or guilty?
_____ H. Did you have trouble concentrating?
_____ I. Did you think about death or suicide or did you want to die?

Have you ever considered suicide?_____ homicide?_____
If yes, do you have a plan? If yes, describe

Below are some examples of abuse. Please check or describe the abusive acts you have committed in this relationship.

1. Physical Abuse

type	yes	no	how often	comments
slapped	___	___	_____	_____
punched	___	___	_____	_____
choked	___	___	_____	_____
pulled hair	___	___	_____	_____
pushed	___	___	_____	_____
restrained	___	___	_____	_____
kicked	___	___	_____	_____
used a weapon	___	___	_____	_____
threw something at victim	___	___	_____	_____
pressured or forced sex	___	___	_____	_____
violent sex attacked breasts or genitals	___	___	_____	_____
stabbed	___	___	_____	_____
shot	___	___	_____	_____
tried to drown or smother	___	___	_____	_____
other	___	___	_____	_____

2. Intimidation (frightened victim by certain looks, gestures, actions, smashing things, destroying property, displaying weapons...is victim afraid of you?)

3. Emotional Abuse (put downs, name calling, humiliation, trying to make victim feel guilty)

4. Isolation (keep victim from going where he/she chooses, listen to phone conversations, check whereabouts, open mail, follow)

5. Minimizing, Denying, Blaming (making light of abuse, saying it didn't happen, saying it's the victim's fault)

6. Using Children (Instilling guilt about children, using visitation to harass victim, threatening to take children away)

7. Male Privilege (treating victim like servant, acting like "the king of the castle", making all the big decisions)

8. Economic Abuse (prevent victim from working outside the home, making him/her ask for money, not letting victim know family income, taking victim's money)

9. Coercion and Threats (threats to take away children, to harm victim or family or friends, to report to HRS, to destroy property, to make victim do something illegal, threats to commit suicide)

10. Violence against Others (including children and including violence against same sex). Have you used a weapon such as a club, tire iron, stick, knife etc?

_____

Prior Arrests/Convictions:

Date	Charge (Note whether felony or misdemeanor)	Disposition

Have you been in jail? _____ How many times? _____

What were the lengths of time?_____

Have you been in prison? _____ How many times? _____

What were the lengths of time?_____

Interviewer comments: (Include impressions about potential lethality, and possible problems)

_____

_____

_____

_____

_____

_____

Interviewer (print or type name) signature date

SI: Part 1

The following are some questions about your life as a child.

_____1. Did your teacher(s) feel that you could do better in grade school?
_____2. Were you ever suspended or expelled from school?
_____3. Did you ever play hooky from school at least five times in a year?
_____4. Did you ever start fights in school?
_____5. Did you ever run away from home overnight at least twice?
_____6. Did you tell a lot of lies when you were a child?
_____7. When you were a child, did you steal things from other children or from stores or from your parents?
_____8. Did you ever try to damage someone's car or property?
_____9. Were you ever arrested as a child or sent to juvenile court?
_____10. Before you were 15, did you get drunk more than once?
_____11. Did you use drugs more than once before you were 15?
_____12. Did you have sex before you were 15?

SI: Part 2
The following are some questions about your life after age 18.

_____1. Have you ever been arrested for anything other than traffic violations?
_____2. Have you ever been convicted of a felony?
_____3. Have you ever been paid for having sex with somebody?
_____4. Have you ever made money finding customers for prostitutes?
_____5. Have you ever made money outside the law?
_____6. Have you ever been sued for a bad debt or had anything repossessed because you were not making payments?
_____7. Have you been divorced more than once?
_____8. When you were married, did you separate more than once?
_____9. Have you had sex with as many as ten people within one year?
_____10. Have you ever been the first to throw something at your spouse or intimate friend more than once?
_____11. Have you ever spanked a child hard enough to bruise the child?
_____12. Other than your spouse or intimate friend, have you ever hit anybody?
_____13. Since you were 18, have you had three or more jobs within a five year period of time?
_____14. Have you ever quit a job before you had another job lined up three or more times?
_____15. On any job you've had since age 18, were you late or absent at least three times in a month?
_____16. Have you ever used an alias?
_____17. Have you ever bummed around for over a month without having a job or a regular place to live?
_____18. Have you ever been without a home for over a month?
_____19. Have you ever been arrested for drunk driving or had an auto accident while drinking?
_____20. In your whole life have you had more than three traffic tickets?

AI: Part 1

_____ 1. Has your family ever said that you were drinking too much?
_____ 2. Have your friends, your doctor, your nurse or counselor or your clergyman ever said that you were drinking too much?
_____ 3. Have you ever had problems at school or on the job because of your drinking?
_____ 4. Did you ever get kicked out of school or lose a job because of your drinking?
_____ 5. Did you ever get arrested for drunk driving or have an auto accident because you were drunk?
_____ 6. Have you ever been arrested for disturbing the peace while you were drinking?
_____ 7. Have you ever gotten into physical fights while you were drinking?

AI: Part 2

_____ 1. Have you ever drunk as much as three six-packs of beer or three bottles of wine or one fifth of liquor in one day?
_____ 2. Have you ever wanted to stop drinking, but could not?
_____ 3. Have you ever made rules for yourself to control your drinking?
_____ 4. Have you ever had a blackout while drinking so that the next day you could not remember what you said or did?
_____ 5. Have you ever gone on benders that lasted at least a couple of days?
_____ 6. Have you ever kept drinking when you had a serious illness which would be made worse while drinking?
_____ 7. Has there been a time in your life when you had to have a drink so you could do your ordinary work?

APPENDIX G: SAFETY PLAN

G.1 Sample Safety Plan
G.2 Protection Plan
G.3 Safety Plan
G.4 Components of a Short-Term Safety Plan

Reference: Chapter 5.4 g.

☑ If you are dealing with a competent abuse victim, it is important to discuss safety issues and develop a safety plan. If there is some question about their competency and ability to evaluate the consequences of their decisions, then an emergency referral to Adult Protective Services and the police should be made. Otherwise, ask him or her if she or he feels safe and help the patient look at available options.

- Remind the patient that he or she can call 911 in case of an emergency.
- Does she or he have friends or family with whom she or he could stay?
- Does she or he want immediate access to a shelter?
- If not, give information on shelters and emergency services to access at a later date.
- Returning home, are there conditions which limit her or his ability to seek help in a crisis situation? If so, consider alternatives (Life-Line, telephone reassurance, etc.).
- Does she or he have a disability that requires assistance? Give referrals for alternative care providers, if needed.
- Does she or he want access to counseling to help deal with victimization?

☑ Use empathic, active listening skills. Competent abuse victims can and will evaluate their own situations. The health care provider gives feedback and a realistic assessment of the situation and thereby encourages an informed decision.

☑ As long as a person is competent, she or he has the right to chose to stay in an abusive environment. It is often difficult to accept this with an older or disabled victim, yet it is important to respect and support their right to make their own decisions. Health care providers empower abuse victims by this action and encourage the victim's own self care which is important. Survivors need the positive message that they are capable of making decisions. Decisions must be made with safety, information, and emotional support in mind for the survivor.

☑ Many programs have a safety plan form that is filled out with the victim in order to increase her self respect for the efforts she has made to protect herself and the children, and to ensure that she knows the options available to her and feels ready to use them. Three examples of safety/protection plans are on the following pages.

Reference: Chapter 5.4 g.

G.1 SAMPLE SAFETY PLAN

A safety plan, or protection plan, is a tool to help you identify possible ways to protect yourself and your children. The protection plan will give you an awareness of your personal and community resources. Also, it will help you to identify the signs and situations that may precede a violent episode.

We know from research and experience that violence repeats itself and gets worse. We will feel more comfortable working with you after we know that you have a plan to help you get to a safe place if you anticipate or experience your partner's violence again. Answering the following questions will help with that plan.

1. What are some cues, behaviors, or circumstances that have happened before an abusive situation in the past? (i.e. time of day, chemical use, discussion about money, locations, relatives visiting, stress level of partner, etc.)

2. What kinds of things have you tried to protect yourself and your children in the past?

3. Have any of the methods worked?

4. What people or organization can you turn to for help? (Look up the numbers and write them down.)

5. Are you familiar with the legal protection available to you? They are:

6. Are you familiar with the medical services available to you? They are:

It is a good idea to keep a bag of clothes for you and your children packed in case you need to leave quickly. Can you have some money tucked away? You might need the following papers, so have them packed and bring them with you if you can:

- Birth certificates
- Social security numbers
- Any divorce papers or legal action

If I am in a situation where I am afraid violence will occur or is occurring towards me or my children, *I know that the following options are available to me:*

- Relatives or friends I can call for support and/or for a safe place to stay:
- The phone number for the shelter for battered women where I can stay in safety and get other support and help is:
- I can call the police at 911.
- The address and phone number to get an order for protection are:
- One other thing I can do is:

Signed

Intake Person

Note: This can be done in person or over the phone. If done in person, keep a copy for the women's file. If done over the phone, have her pick it up or send it to a *safe place* where she can pick it up.

G.2 PROTECTION PLAN

The objective of our program is to prevent future violence. We know from research and experience that violence repeats itself and gets worse. We believe that the violence is not your fault and you neither cause nor deserve it. Now is the time to plan what to do if there is further violence. A protection plan gives you a way to protect yourself and your children, both by using personal and community resources and becoming aware of signs.

****

1. CUES: SITUATIONAL:

MY CUES	HIS CUES
PHYSICAL: How does your body register stress? (head, face, shoulders, back, digestive system...)	PHYSICAL: When he is under stress or is escalating:
EMOTIONS you experience under stress or in danger.	ACTIONS/BEHAVIORS:
SELF-TALK: What you think and say to yourself.	RED-FLAG WORDS: Things he says when he's escalating:

FANTASY: What things do you imagine or wish happening to you or him?

BEHAVIORS/ACTIONS which you have done in the past to keep yourself safe:

****

2. RESOURCES: Who are the people and to what organization can you turn for help?

Personal: Friends
Family
Neighbors

Legal: _____ for an Order for Protection in _____ County.
_____ Advocate at _____in _____ County.

Shelter:

Medical: Hospital Emergency Services: 911

Crisis #

G.3 SAFETY PLAN

Name:
Case # _____

A Safety (Protection) Plan is a tool to help you identify possible ways to protect yourself and/or your children. The Plan will give you an awareness of personal and community resources. Also it will help you to identify the signs and situation that may precede a violent episode.

We know from research and experience that violence repeats itself and gets worse. We will feel more comfortable working with you after we know you have a plan to help you get to a safe place if you anticipate or experience your partner's violence again. Answering the following questions will help with that plan.

1. What are some cues, behaviors, or circumstances that have happened before an abusive situation in the past? (For example, time of day, alcohol/drug use, money problems, relatives visiting, stress level of partner.)

2. Partner's behavior when angry: (For example, yells, becomes withdrawn, change in facial expression, wrings hands, paces, leaves the room, throws objects, gets close to me, clenches fists. Other.)

3. What people or organization(s) can you turn to for help?
   Relatives_____ Friends_____ Shelter_____ Military_____

4. What kinds of things can you do to protect yourself and/or your children?

5. Are you familiar with the legal protection available to you? Yes_____ No_____
   You can call the police at 911
   You can get an Order of Protection at:

   Thurston County Courthouse
   2000 Lakeridge Drive
   Olympia, WA
   Phone: 752-2500

   Pierce County/City Building
   930 Tacoma Ave. S, Room 108
   Tacoma, WA
   Phone: 592-7455

6. Given Domestic Violence Services pamphlet.

_____
Signed Date

_____
Social Worker (Assistant) Date

G.4 COMPONENTS OF A SHORT-TERM SAFETY PLAN

WHAT CAN YOU DO IF YOU STAY?

Perhaps you've decided you can't leave just yet. You don't have skills for the job market. You have no supportive people in your life. Your children are not yet in school. You feel you have to take a chance on staying a while longer.

If you're serious about leaving later, you'll have to make some changes now. Make a friend. Join a support group. Get job skills through on-the-job training, classes, or volunteer work. Otherwise, you'll be in the same position later as you are now.

Some men bully only those who are afraid of them. You may be able to do some "forbidden" things by just *doing* them. However, it's a risk. Plan an emergency escape to a safe place before you take that risk. (See below.)

Many men are sorry right after they've battered. This is sometimes called "the honeymoon period." They're willing to give in to some things you want. this is a good time to get out of the house and meet people. It's a good time to start the changes you plan.

It may be hard to face new people with a black eye. Try to make yourself do it, anyway. Once your bruises fade, it's easy for your man to forget what he did. You won't be able to count on his being sorry. You'll be afraid of being hit again if you try something new.

HOW TO PLAN FOR AN EMERGENCY ESCAPE

Whether you leave or stay, you'll be safer if you have an escape plan.

Learn to know the signs of coming violence, if you can. Do they begin weeks before the actual abuse, or only hours? Or minutes? *Write down the signs*. Write down changes in the way he acts, or in his tone of voice. This will help to get you into action before the violence starts. You won't be so likely to tell yourself: "Oh, I'm just imagining things."

Where can you go for safety? The best choice is to the home of someone who cares for you. Someone who will support you, no matter what you do. This might be a good friend or a relative. Otherwise, choose a hotel/motel *ahead of time*. Practice getting there from your house when you're not under stress. You should also be prepared with these things:

- money for cab fare
- change of clothes for yourself and/or children (hide clothes away from home, at a neighbor's house, or at your job)
- money for one or more nights at a motel
- extra house key and car key
- list of emergency phone numbers

Plan for a quick getaway, day or night. Find excuses to go outdoors that won't make him suspicious. Make a habit of taking out the garbage at midnight. Or walking the dog twice a day.

When you need to escape, pretend you're going to do one of those tasks. Once outside, just keep going. Get into the car and drive off quickly. Or keep walking until you get to a phone.

If you have children, make plans for taking them. Plan to tell the man you hear the baby crying. If you can, pick her/him up and exit from a back door or window. Prepare older children to go to a neighbor's house if you can't get away. They can call the police. Officers may help you leave with younger children.

If you must leave without the children, go back for them. Return to the house with a police officer as soon as you can. Or pick them up at school. Your right to custody can be endangered if they are not with you.

PREPARING TO LEAVE PERMANENTLY

After you have an emergency plan, you can think about leaving for good. If you plan to *stay away*, here are some practical things to think about.

Protect Your Money and Property

Laws about property rights for married people are different from state to state. They are also different for people who just live together. You'll need a lawyer's advice on what a court might award you. Also, on what things you can legally take with you. You then need to plan how to get the things out.

Remove as many personal belongings as you can several weeks before you leave. Include family photographs and sentimental objects, if you want them. Those are the things he might destroy.

Try to take important items to a friend for safe-keeping. This may be too risky if the man notices everything you do. If he does, make a list of important things you want to take. (Don't forget items important to your children.) Move them little by little to two or three places in the house. Then you'll be able to pack them more quickly when you do leave.

Remove your things when your partner isn't at home. Try to have a friend with you, in case he returns. Find out whether the police can be there. There may also be other community agencies that can help you.

Unless a lawyer says you can't, take half the money in checking accounts. Do the same with savings accounts. Don't leave your share of money in joint accounts to take out later. Once you've left, your partner may withdraw all money from the accounts. He may take your name off credit cards. He may change all the locks on the doors. You could find yourself with no money or property twenty-four hours after you leave.

It's possible you don't know exactly what you and he jointly own. Look for papers that show stocks, property, loans, insurance policies you both own. Write down all the information. If you can do it safely, xerox the papers. If necessary, give all papers and lists to a friend you trust.

It isn't mean or unfair to take what is yours. Don't deprive yourself or your children of what you need because of guilt feelings.

Plan Where to Go

Try to find a place to live before you leave. It might be one of these places:

- a battered women's shelter
- a Safe Home for abused women
- a friend or relative's home
- an apartment of your own

There are now battered women's shelters and Safe Homes in many communities. Chapter 15 tells how to find out about them.

Try to decide where you want to live permanently. You might want to move to a different city. Sometimes a local shelter can help you find temporary shelter in a new city. Check housing ads so you'll know what to expect in your price range. You may need public housing or welfare assistance. Find out what papers you'll need to show you qualify. Get them together to take with you.

The better you prepare now, the easier it will be for you later.

NOTES

APPENDIX H: PROTOCOL FOR THE INITIAL IDENTIFICATION, ASSESSMENT, AND DISPOSITION OF SPOUSE ABUSE

MEDCOM OP 33-R, OP 28A-R, HSC OP 28C-R, HSC OP 28D-R

Reference: Chapter 5.4 h.

H.1 Purpose: To establish standardized guidelines and procedures for the initial identification, assessment, and disposition of spouse abuse cases.

H.2 Definition: Spouse abuse is an assault, battery, threat to injure or kill, an unlawful act of force or violence, or emotional maltreatment inflicted by one spouse in a marriage against the other when the victim, regardless of age, is authorized treatment in a medical treatment facility of the Military Service. Emotional maltreatment is conduct which, although not criminal, is so offensive to the victimized spouse that a reasonable person would find such conduct abhorrent within a marital relationship.

H.3 Evidence:

a. Treat all information as forensic evidence.
b. Photographs will be taken as soon after the injuries as possible and again 30 hours after the incident.
c. Maintain custody chain of evidence IAW standard police Chain-of-Custody procedures.

H.4 Indicators * of Possible Spouse Abuse:

a. Repeated medical treatment or emergency room (ER) visits for physical injury.
b. Inadequate, inconsistent, or evasive explanation of injuries.
c. Patient threatened or injured with a weapon.
d. Patient severely beaten or battered.
e. Any injury during pregnancy.

f. Severe strangulation.
g. Patient sexually assaulted.
h. Patient has fractures.

*Indicates possible severe spouse abuse. Requires telephonic consultation with the On-call Social Worker.

H.5 Communicating With The Patient:

a. Ensure privacy and confidentiality.
b. Be direct, empathetic, and non-judgmental.
c. Ask open-ended questions.

H.6 Medical History and Physical Examination (Check & Document):

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	**SPOUSE ABUSE CHECKLIST** *For use of this overprint see MEDCOM Pam 608-1.*	OTSG APPROVED *(Date)*

PART 1: MEDICAL HISTORY AND PHYSICAL EXAMINATION

NOTE: It is important to fully examine the patient and document the results clearly and concisely.

	YES	NO
A. PATIENT'S CHIEF COMPLAINT		
B. TIME, DATE, AND LOCATION OF INCIDENT		
C. NAME AND RELATIONSHIP OF INDIVIDUALS WHO ACCOMPANIED PATIENT ON THIS VISIT		
D. NAME AND RELATIONSHIP OF ALLEGED PERPETRATOR		
E. DO THE PATIENT AND ALLEGED PERPETRATOR LIVE TOGETHER?		
F. SUSPECTED SUBSTANCE USE/ABUSE? (If yes, identify):		
G. IS THE PATIENT TAKING ANY MEDICATIONS? (If yes, identify):		
H. ALERGIC TO ANY MEDICATIONS? (If yes, identify):		
I. TOXICOLOGY SCREENS COMPLETED, AS CLINICALLY INDICATED? (If yes, identify):		
J. IS THE PATIENT PREGNANT?		
K. PREGNANCY TEST OFFERED?		
L. PREGNANCY TEST CONDUCTED?		
M. WAS THE PATIENT A VICTIM OF RAPE, SEXUAL ASSAULT, OR NON-CONSENTING SEXUAL CONTACT? (If yes, identify):		
N. MTF COMMANDER NOTIFIED OF SEXUAL ASSAULT?		
O. STD SCREEN OFFERED?		
P. STD SCREEN CONDUCTED?		
Q. HIV SCREEN OFFERED?		
R. HIV SCREEN CONDUCTED?		
S. WAS THE PATIENT'S LIFE OR SAFETY THREATENED?		

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

	YES	NO
T. WAS ANY WEAPON USED IN THE MALTREATMENT? (If yes, identify):		
U. ANY CURRENT INJURIES? (If yes, identify):		
V. INJURIES DOCUMENTED ON ENCLOSED DIAGRAMS?		
W. PHOTOGRAPHS TAKEN?		
X. IS PATIENT SUICIDAL OR HOMICIDAL? (If yes, indicate which and consult Psychiatry):		
Y. SOCIAL WORK SERVICE NOTIFIED?		
Z. MILITARY POLICE OR LOCAL POLICE NOTIFIED? (If yes, who?):		
AA. SPOUSE ABUSE AND SHELTER INFORMATION OFFERED?		
BB. DOES PATIENT FEEL SAFE TO RETURN HOME?		
CC. HAVE ARRANGEMENTS BEEN MADE FOR THE SAFETY OF THE CHILDREN?		
DD. IS THE LOCATION OF THE ALLEGED PERPETRATOR KNOWN?		
EE. HAS THE PATIENT BEEN INFORMED THAT THE SITUATION IS POTENTIALLY LETHAL AND THAT OTHER ALTERNATIVES ARE AVAILABLE TO HER/HIM?		
FF. OTHER (Specify)		

PART 2: SOCIAL WORK ASSESSMENT

The on call social worker will conduct a brief social work assessment of the patient to include the following.

A. EXPLANATION OF THE CURRENT INCIDENT:

B. HISTORY OF RECENT SPOUSE ABUSE:

C. RISK ASSESSMENT:

D. SAFETY PLAN (To include support systems):

E. DIAGNOSTIC IMPRESSION(S):

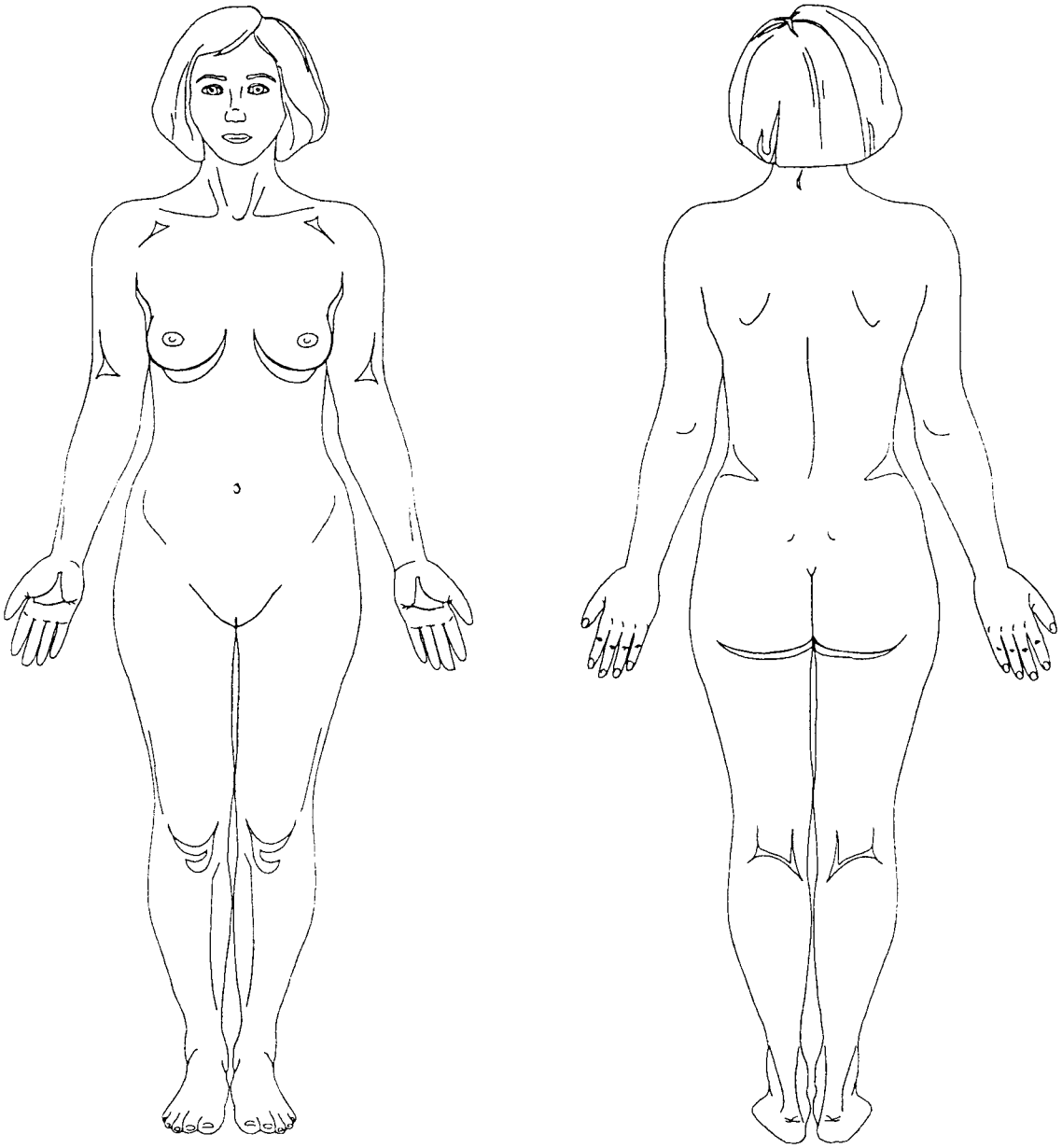
F. SPONSOR'S COMMAND INFORMED? ☐ YES ☐ NO

G. REFERRAL AND FOLLOW-UP SERVICES SCHEDULED? ☐ YES ☐ NO

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	**SPOUSE ABUSE PHYSICAL EXAMINATION DIAGRAM - FEMALE** *For use of this overprint, see MEDCOM Pam 608-1.*	OTSG APPROVED *(Date)*



(Continue on reverse.)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

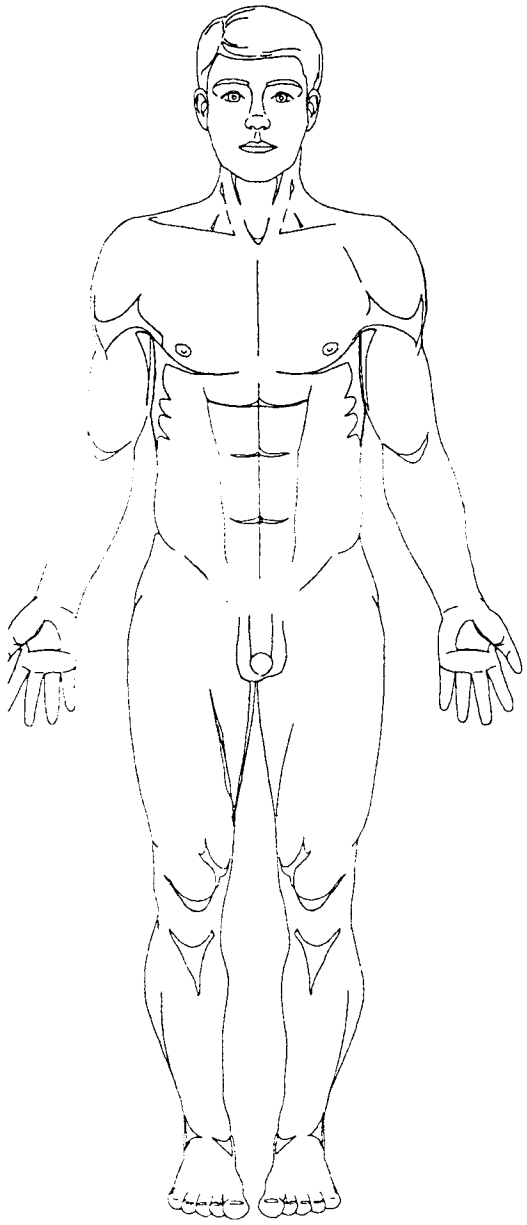
PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

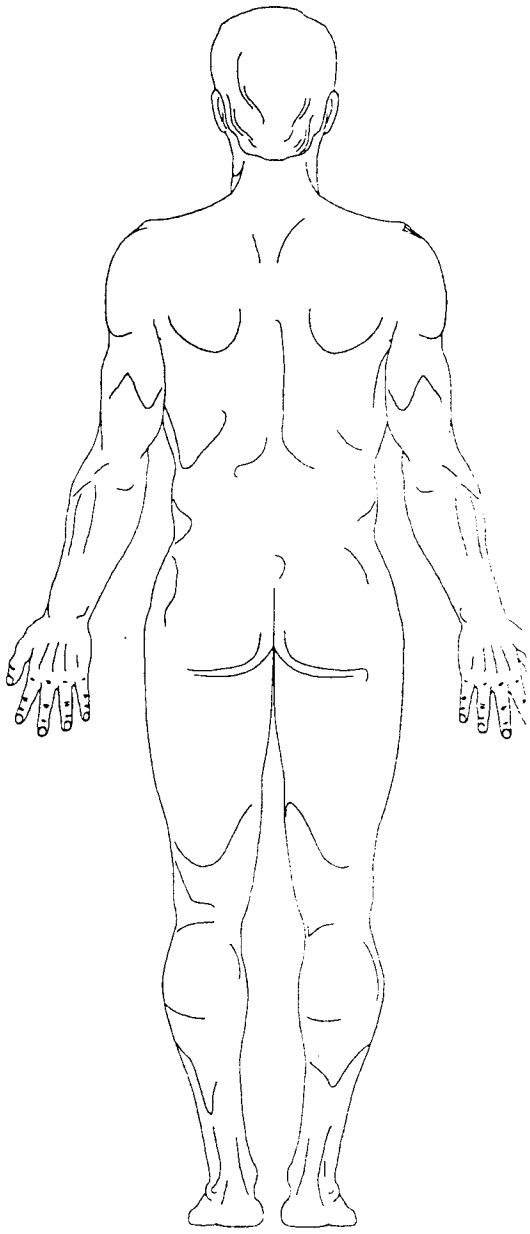
- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	**SPOUSE ABUSE PHYSICAL EXAMINATION DIAGRAM - MALE** *For use of this overprint, see MEDCOM Pam 608-1.*	OTSG APPROVED *(Date)*





(Continue on reverse.)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

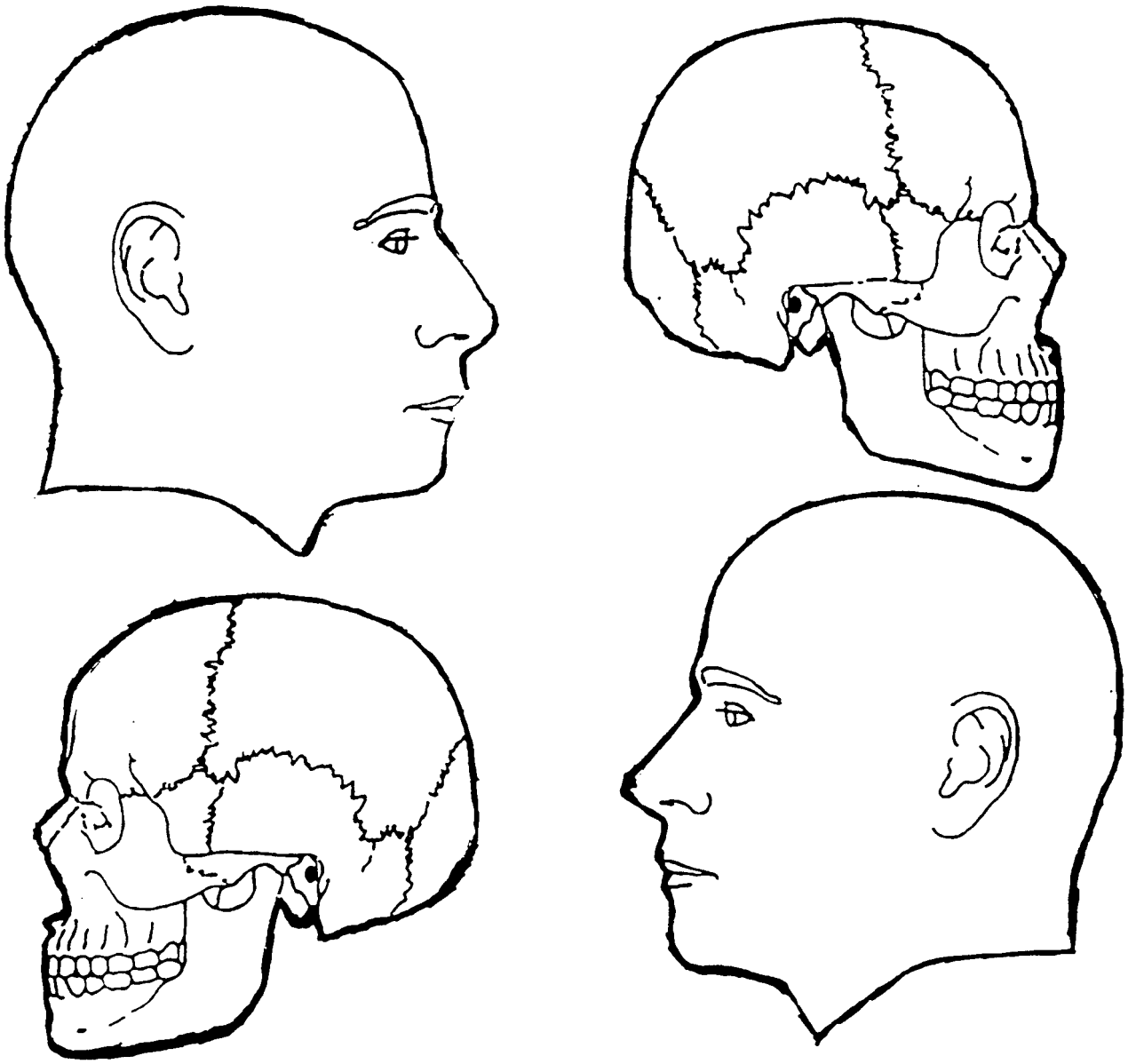
MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **SPOUSE ABUSE PHYSICAL EXAMINATION DIAGRAM - HEAD, SURFACE AND SKELETAL ANATOMY**

For use of this overprint, see MEDCOM Pam 608-1.

OTSG APPROVED *(Date)*



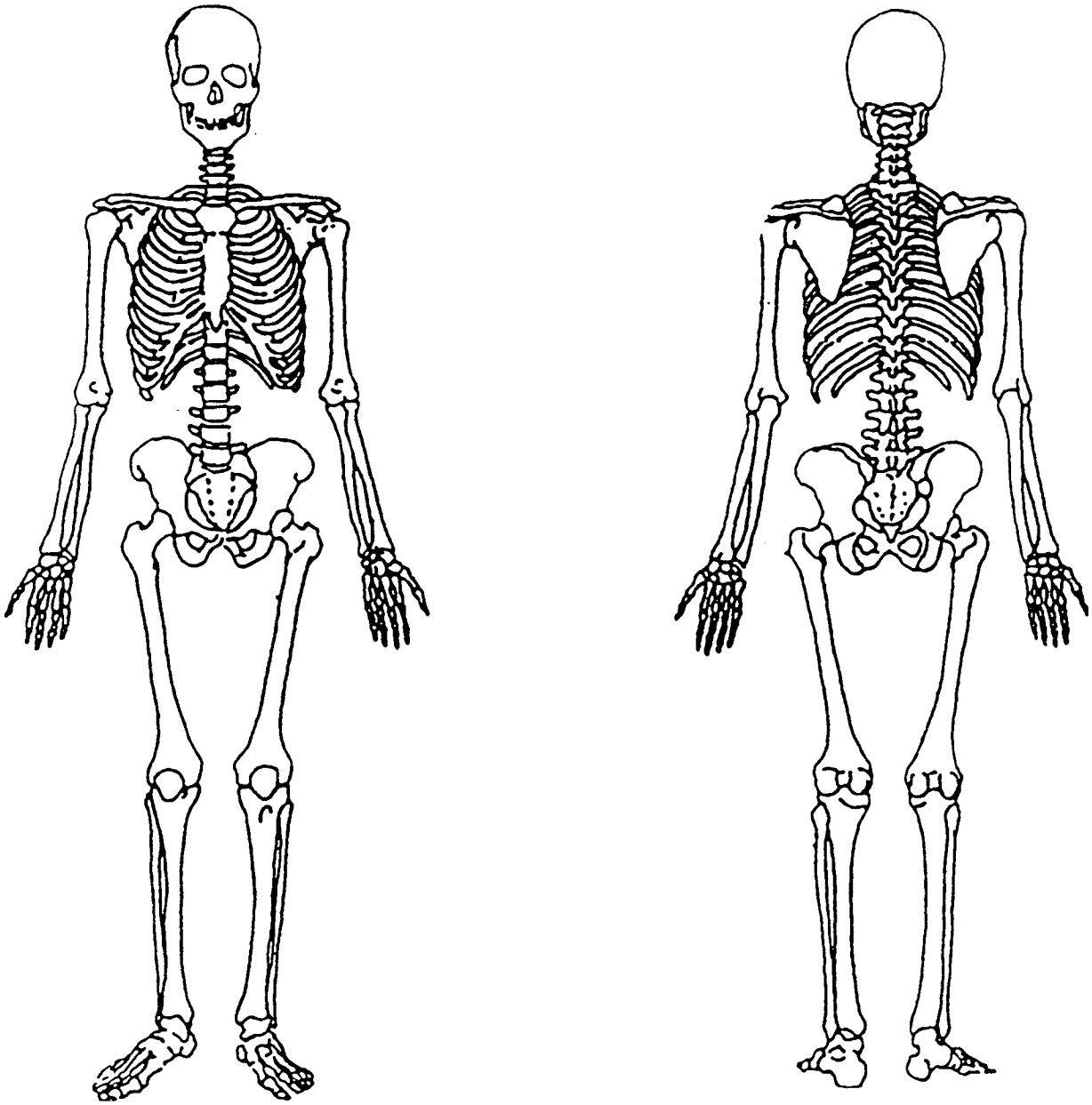
(Continue on reverse.)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*	☐ HISTORY/PHYSICAL ☐ OTHER EXAMINATION OR EVALUATION ☐ DIAGNOSTIC STUDIES ☐ TREATMENT	☐ FLOW CHART ☐ OTHER (Specify)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	**SPOUSE ABUSE PHYSICAL EXAMINATION DIAGRAM - SKELETON** *For use of this overprint, see MEDCOM Pam 608-1.*	OTSG APPROVED *(Date)*



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REPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

ATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, rst, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

APPENDIX I: SPOUSE ABUSE MATRIX

MEDCOM Form 694-R

References: ***Chapter 4.2 a (7)***
Chapter 5.2 b (4)
Chapter 5.4 m.
Chapter 5.5 d.
Chapter 6.1 a.

The spouse abuse matrix is designed to be a guide for the Case Review Committee (CRC) to determine the level of severity of abuse, and appropriate clinical and command intervention(s). Unit commanders retain the ultimate responsibility and command prerogatives.

Additionally, on the following pages are the Souse Abuse Manual (SPAM) Assessment Worksheet and instruction worksheet which will facilitate an understanding of the use of the matrix in the CRC/treatment process. The FAP Assessment Flow Chart outlines the assessment based decision making process of the CRC.

The enclosed bibliography supports this assessment process.

SPAM Matrix Instruction Worksheet

1. The following matrix is designed as a guide for the Case Review Committee (CRC) to determine the appropriate level of clinical and command interventions. The use of the SPAM must be based on the receipt of the report of abuse regardless of source. A report is the point of entry for FAP assessment, intervention and services. Without a report there is no regulatory basis for FAP involvement and presentation of a case to the CRC.

2. Use of the Spouse Abuse Matrix is an assessment-based process. An assessment is accomplished with the full accumulation of information from intake, social history, and clinical and collateral interviews. To facilitate documentation of information gathered at intake, social history, and interviews, complete the following worksheet, MEDCOM Form 694-R, SPAM Assessment Worksheet, and file in the standard case record at TAB A. Complete a separate worksheet for each spouse in a reported spouse abuse instance. Essential to an adequate assessment is consideration of the following:

    a. Presence, severity, and/or frequency of injury

    b. History of abuse in family of origin

    c. History of abuse in previous relationship

    d. History of abuse in present relationship

    e. Special needs of family members, i.e., disability, illness

    f. Victim characteristics

    g. Presence of rigid traditional roles

    h. Life circumstances, i.e., debt, death, transfers, etc.

    i. Control issues

    j. Impulse control

    k. Responsibility for or blame for actions

    l. Current or previous mental health diagnosis

    m. Spirituality

    n. Work performance

    o. Level of involvement in the community

p. Attitude toward the evaluation

q. Individual or family strengths

3. IAW AR 608-18, paragraph 2-4a, 3-16b, 3-22a, and 3-28, all reported Family Advocacy Program (FAP) cases are assigned a case number and presented to the CRC for determination, regardless of reporting source, to include self referrals.

4. Cases must be presented IAW format and information requirements defined in AR 608-18, FAP, and MEDCOM Pamphlet 608-1, FAP. Presentations are assessment based and provide the CRC required case information within a situational context.

5. Cases found during the assessment process and the pre-CRC clinical staffing to be without merit or foundation (non-credible) may be presented to the CRC in summary form and with the recommendation to the team to not substantiate (Matrix Level I).

6. Cases found during the assessment process and the pre-CRC clinical staffing to be an abusive event that was an isolated incident should be presented to the CRC in full with a recommendation for team determination. If the team determines the allegation/report to be not substantiated, but that risk factors exist for the family or individuals, a plan to address the family's's ongoing needs must be developed and offered at the appropriate Matrix Level.

7. Cases assessed and pre-staffed and believed to be a Matrix Level III, IV, or V due to the intent to inflict harm, an abusive pattern, degree of injury, or the degree of risk must be presented to the CRC, this includes supporting information obtained in the assessment process. Presentations to the team will include the recommendation to substantiate and a proposed treatment plan at the appropriate Matrix Level.

8. The CRC is the determining body to substantiate or to not substantiate a case and the approving body for a treatment plan. Treatment plans based on the matrix and needs determined during assessment may not always be a "match" for the levels (mild, moderate , or severe) reported to the Army Central Registry (ACR) on the DD Form 2486. The matrix is used to make a clinical determination based on clinical assessment-based decisions. For example, an event may result in a "mild" injury for DD Form 2486 reporting purposes, yet, assessment shows a relationship dynamic with chronic abusive patterns and results in a CRC treatment plan at Matrix Level IV or V. Vice versa, a serious injury reported as abuse may prove to be, after assessment and investigation, an accident and not result in a case that is substantiated, but with an offer of support services based on minor risk factors (Matrix Level II).

SPOUSE ABUSE MATRIX LEVEL I

ASSESSMENT RESULTS	INTENT OF INTERVENTION	CLINICAL INTERVENTION	COMMAND INTERVENTION
Physical Abuse: None identified. **Non Physical Abuse:** None identified. **RISK**: None.	a. To determine credibility of the report. b. To determine the need for FAP services. c. Recognizes many referrals are not credible for FAP, but families would benefit from other military and/or civilian resources.	a. CRC presentation made in summary form with the recommendation to the team to not substantiate. b. Triage for credibility or referral and assessment for FAP and other services. c. Referral to other agencies as indicated. d. Command consultation. e. Follow-up treatment, if indicated. f. Other appropriate interventions, as indicated.	**Command Options Include**: a. Encourage compliance with the Case Review Committee recommendations. b. Command intervention should be supportive of the soldier and family. c. Use unit/community resources as indicated. d. Punitive measures are not indicated. e. Focus should be to maximize the soldier's and family's potential.

SPOUSE ABUSE MATRIX LEVEL II

ASSESSMENT RESULTS	INTENT OF INTERVENTION	CLINICAL INTERVENTION	COMMAND INTERVENTION
Physical Abuse: Isolated incident with or without minor physical injury (push, shove, and slap). **Non Physical Abuse**: Isolated incident of berating or disparaging remarks. **RISK**: Minimal risk with or without intervention. No history or pattern of abuse. Willingly seeks assistance with needs that might lead to family violence. Preponderance of worksheet indicators are low.	a. Prevent escalation or repetition of inappropriate behavior. b. Reinforce family strengths. c. Assist the soldier with good career potential. d. Provide clinical counseling sessions intended to address the incident. e. Determine ongoing services/ needs of the family members and the offender.	a. CRC presentation made in full with the recommendation to the team to "substantiate" or to "not substantiate" and to offer services for identified needs. b. Command consultation and one or more of the following are required: 1) Voluntary short-term treatment for the family, couple, individuals(s) as clinically indicated. 2) Refer to other agencies and/or services as indicated. c. Reassess subsequent incidents of the same or greater risk and/or severity. Modify the treatment plan as indicated by the assessment.	**Command Options Include**: a. Encourage compliance with the Case Review Committee recommendations. b. Use unit/community assistance resources as indicated. c. Commander or 1SG conducts supportive counseling session with soldier. d. The commander may restrict the service member to the barracks or BOQ.

NOTE: At each level, performance outcome measures should be applied to determine the success of intervention.

SPOUSE ABUSE MATRIX LEVEL III

ASSESSMENT RESULTS	INTENT OF INTERVENTION	CLINICAL INTERVENTION	COMMAND INTERVENTION
Physical Abuse: Isolated intentional minor physical injury where no medical treatment is required (bruises, welts, scratches, black eye, etc.). **Non Physical Abuse**: Isolated, intentional incident of berating or disparaging remarks or threats. The offender does not have a history of more extreme abuse in previous intimate relationships and accepts some personal responsibility for his/her actions. **RISK**: Minimal with intervention. Possible emerging pattern of abuse. Preponderance of worksheet indicators show a developing trend to increased risk.	a. Determine possible combination of UCMJ actions and rehabilitation. b. Identify critical tasks which include safety planning, prevention of escalation, treatment, and education. c. Ensure the safety of the victim as the primary goal. (Cases at this level are usually acts of poor judgment, but are not considered threatening to life and limb.) d. Consider a combination of treatment and prevention services.	a. CRC presentation made in full with a recommendation to the team to substantiate. b. Offender participates in an intensive treatment program recommended for at least 3 months in length. c. Treatment provided for victims and/or family members as clinically indicated. d. Notify the commander if the soldier and/or spouse is non-compliant with the recommended treatment plan. e. Establish and document a safety plan to include shelter options. f. Reassess subsequent incidents of the same or greater risk and/or severity. Modify the treatment plan as indicated by the assessment. g. Consider referral to the Victim Advocate and/or Victim Assistance Programs. h. Following the completion of treatment, monitor the case for 3-6 months or as clinically indicated.	**Command Options Include**: a. IAW AR 608-18, 1-7 (b), page 3-4, unit commanders will support and comply with CRC recommendations to the maximum extent possible. Provide nonconcurrence with the CRC treatment recommendations in writing through the chain of command to the MTF commander. b. Command intervention should not be career threatening as long as the soldier completes the recommended treatment. c. The commander may consider non-judicial punishment and/or appropriate administrative action. d. The commander may revoke the pass privileges of the service member to assure the service member remains in the barrack or BOQ when not on duty.

NOTE: At each level, performance outcome measures should be applied to determine the success of intervention.

SPOUSE ABUSE MATRIX LEVEL IV

ASSESSMENT RESULTS	INTENT OF INTERVENTION	CLINICAL INTERVENTION	COMMAND INTERVENTION
Physical Abuse: Non-accidental physical injury. Assault results in serious injury (i.e., broken bones, severe lacerations, internal injuries, significant bruising, trauma to head, face and eye). Includes hitting with objects or weapons. Harm to a pregnant spouse or fetus. Medical treatment may be indicated. Chronic pattern of abuse by offender involving one or more incidents of abusive behavior that causes injury to the victim or puts the victim at risk of serious injury, actions to keep the victim in a state of fear. Coerced or forced sex. **Non Physical Abuse**: An emerging pattern of verbal intimidation (instilling fear), pattern of isolation and/or economic restrictions (discourages the victim's autonomy), pattern of emotional and/or psychological put-downs/insults, erodes the victim's dignity/self-esteem, sporadic insults/emotional abuse. Repeated threats to kill or harm victim, children, family members. Threats about or against children. **RISK**: The victim and family members are at high risk for continued abuse. Preponderance of worksheet indicators represent a pattern of abusive behavior and a high level of risk.	a. Determine possible combination of UCMJ actions and rehabilitation. b. To be put in-place long term intervention to stop or reduce the abuse. c. Ensure the safety of the victim and family members as the primary goal.	a. CRC presentation made in full with a recommendation to the team to substantiate. b. Provide the offender an intensive treatment program for offenders for at least 6-12 months or longer if clinically indicated. c. Provide treatment for victims, family members, and/or offenders as clinically indicated. d. Notify the commander if the soldier/spouse is non-compliant with the recommended treatment plan. e. Establish and document a safety plan/shelter options. f. Reassess subsequent incidents of the same or greater risk and/or severity. Modify the treatment plan as indicated by the assessment. g. Refer to the Victim Advocate and/or Victim Assistance Programs. h. Monitor the case for a minimum of 6 months to 1 year following the completion of treatment.	**Command Options Include**: a. IAW AR 608-18, 1-7 (b), page 3-4, unit commanders will support and comply with CRC recommendations to the maximum extent possible. Provide nonconcurrence with the CRC treatment recommendations in writing through the chain of command to the MTF commander. b. Commander may consider judicial, non-judicial punishment, or other appropriate administrative action. c. Some soldiers at this level may not be candidates for rehabilitation. Command should assess for retention on active duty. d. The case manager will coordinate with command to develop appropriate measures to insure the safety of the victim, the family, and the offender. e. Commander may revoke pass privileges of the service member to assure the service member remains in the barracks or BOQ when not on duty.

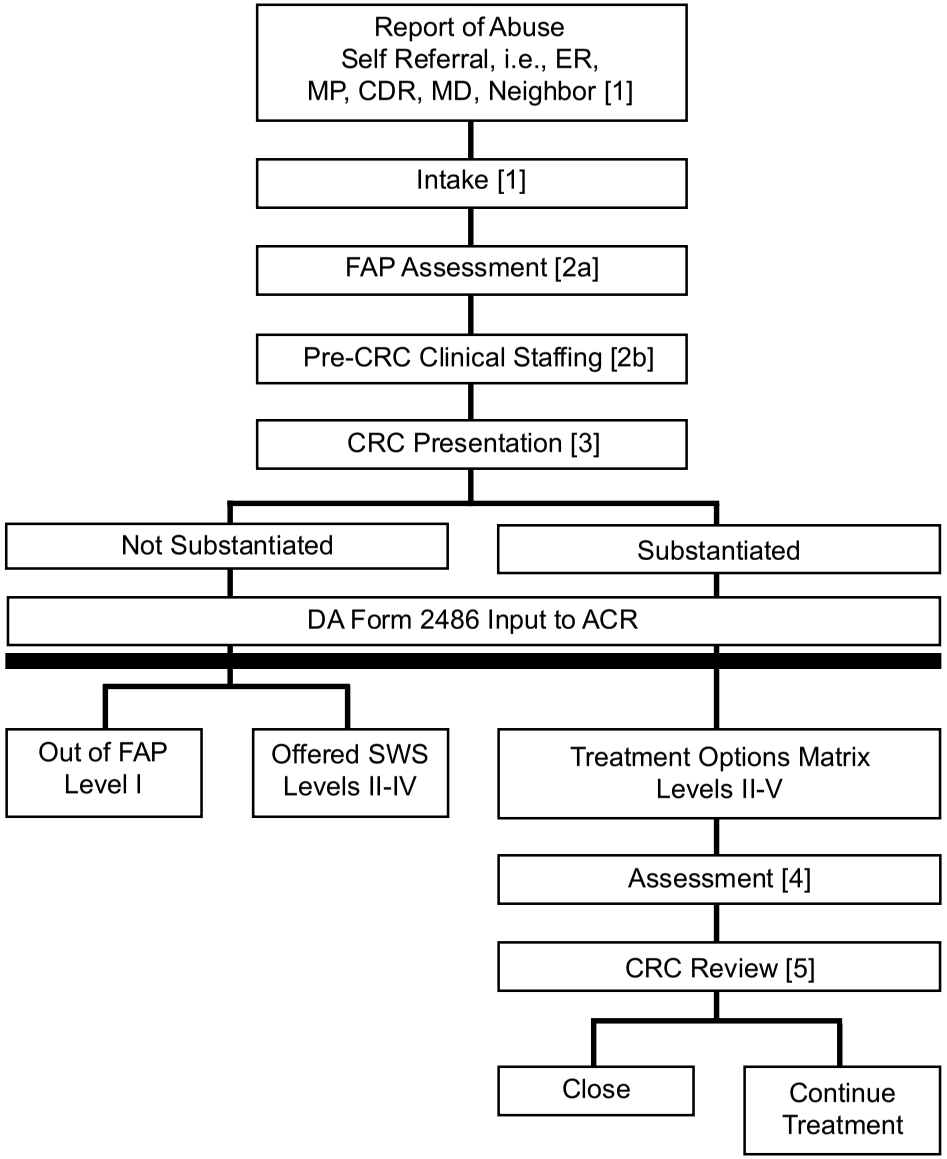
NOTE: At each level, performance outcome measures should be applied to determine the success of intervention.

SPOUSE ABUSE MATRIX LEVEL V

ASSESSMENT RESULTS	INTENT OF INTERVENTION	CLINICAL INTERVENTION	COMMAND INTERVENTION
Physical Abuse: Severe physical injury, subsequent Level IV incident, or death. Medical treatment required. **Non Physical Abuse:** Chronic pattern of restricting spouse's freedom of movements, economic control, emotional abuse, verbal abuse, intimidation, stalking, etc. Repeated threats to kill, maim or injure the victim, family members or pets. Implicit threats or attempt to kidnap or restrict access to children. **RISK:** The victim is at very high risk of continued severe abuse and/or death. Preponderance of worksheet indicators represent chronic abusive behavior.	a. Take action to ensure the safety of the victim and all family members. b. Command should take action to punish, prosecute, and remove the offender from active duty. c. Provide treatment services for the victim and all family members. d. Ensure the offender is offered treatment if indicated.	a. CRC presentation made in full with a recommendation to the team to substantiate. b. Provide the offender Family Advocacy Program treatment as indicated. c. Provide supportive treatment and services for victims and family members to include referral to the Victim Advocate and Victim Assistance Programs. d. Immediately notify the command of severity of subsequent incident(s). e. Establish and document a safety plan to include shelter options, and coordinate with the commander for appropriate safety measures for all family members. f. Coordinate with the state Child Protective Services, if necessary. g. Refer to the Victim Advocate and/or Victim Assistance Programs.	**Command Options Include**: a. IAW AR 608-18, 1-7 (b), page 3-4, unit commanders will support and comply with CRC recommendations to the maximum extent possible. Provide nonconcurrence with the CRC treatment recommendations in writing through the chain of command to the MTF commander. b. Commander should consider judicial, non-judicial punishment, and other appropriate administrative action. c. Consider separation from service. d. The case manager will coordinate with command to develop appropriate measures to insure the safety of the victim, family, and offender. e. The commander should revoke pass privileges of the service member to assure the service member remains in the barracks or BOQ when not on duty.

NOTE: At each level, performance outcome measures should be applied to determine the success of intervention.

FAP ASSESSMENT FLOW CHART



Assessment **[1]**
- MP Report/Verbal
- PCAN/Spouse Medical
- Risk Assessment Form
- Safety Plan

Decision
- Credible?
- Imminent risk?

Manage It
- Commander/1SG (phone)
- Contact Child Protective Services (CPS) as indicated

Assessment **[2a & b]**
- History Form/Psychosocial Assessment
- Intake Package/Scales/ Instruments/Worksheets
- Clinical Interview

Decision
- Credible?
- Imminent danger?

Potential Risk: Manage It
- Communicate it to the Clinical Supervisor, Hospital Commander
- Letter to Unit Commander
- Develop proposed MLP & TP

Assessment **[3]**
- CRC Team Input
- Commander Input
- Other Agency Input
- Substantiated/Unsubstantiated (Admin)

Decision
- Potential Risk-Offender/Victim/ Community/County/Treatment Plan

Manage It
- Communicate Verbally with Unit Commander and Follow-up with Meeting and Form Letter

Status of Assessment **[4]**
- Redo Risk Assessment
- Redo Assessment Worksheet
- Treatment Plan
- Command Input
- Clinical Interview

Decision
- Dangers/Risk

Manage It
- Progress/Recommendations

Communicate It
- Case Review Committee (CRC)

Assessment **[5]**

Decision
- Potential Risk
- Status of Treatment Plan

Manage It
- Communicate it Verbally to Unit Commander in the CRC Meeting
- Letter as Necessary

BIBLIOGRAPHY FOR SPOUSE ABUSE MANUAL (SPAM) ASSESSMENT WORKSHEET

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2. Frequency of Abuse. (Speaks to risk issues).
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Straus, M.A., Gelles, R.J. and Steinmetz, S.K. (1980). Behind Closed Doors: Violence in the American Family**.** N.Y. Doubleday

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16. Attitude Toward Evaluation. (Speaks to level of cooperation, risk).

17. Work Performance.

(Attempt to focus on strengths and protective factors, although clinical experience tells us that "looking good" can also be a risk factor. Can be a source of social support for soldier.)

18. Family Strengths. (Attempt to focus on balancing protective factors).

APPENDIX J: CASE REVIEW COMMITTEE REVIEW PROCESS

- **Memorandum for Commanders, MEDCOM MEDCENs/MEDDACs, ATTN: Chief, Social Work Service**
- **Information Paper: FAP**
- **Acknowledgment of Receipt of Family Advocacy (CRC) Procedures**

Reference: Chapter 5.4 o.

This section underscores the need to provide specific FAP information to individuals whose cases will be presented at the CRC, as reported child/spouse abuse.

NOTES

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

MCHO-CL-H (608-18a)

30 JAN 1996

MEMORANDUM FOR Commanders, MEDCOM MEDCENs/MEDDACs, ATTN: Chief, Social Work Service

SUBJECT: Family Advocacy Program (FAP) Information

1. References:

a. Army Regulation (AR) 608-18, Army FAP, 1 Sep 95.

b. AR 340-21, Army Privacy Program, 5 Jul 85.

c. Health Services Command Pamphlet 608-1, FAP, 27 Jul 94.

d. Protocol for Child Abuse and Neglect (PCAN), Dec 95.

2. Effective upon receipt, provide the enclosed Information Paper to all clients whose cases will be presented to the Case Review Committee as reported child/spouse abuse (you do not present this to individuals or families whose cases are presented to the team as "at risk" for information or staffing purposes).

3. Upon provision to the client, allow time for reading, discussion, and answering any questions on the process that the client may have.

4. Attached to the Information Paper is a receipt. Have the client sign the receipt after discussion. If the client refuses to sign, the case manager should annotate the receipt "refuses to sign," date, and sign the annotation. File the receipt in the client's case record at Tab L. This will become an inspection item.

5. This information paper is a requirement and supersedes any other in use. You may provide additional information to the client on local attachments. You may not delete any information.

6. This information paper does NOT replace the parental advisement letter required by the PCAN. It is an additional requirement.

7. Advise your commander of this requirement and process.

MCHO-CL-H
SUBJECT: Family Advocacy Program (FAP) Information

8. Our point of contact is Mary W. Behrend, Human Resources Management Division, Directorate of Clinical Operations, DSN 471-6767 or Commercial (210) 221-6767.

FOR THE DIRECTOR OF CLINICAL OPERATIONS:

William F. Barko

WILLIAM F. BARKO
Colonel, MS
Chief, Human Resources Management Division

Encl
as

MCHO-CL-H 22 January 1996

INFORMATION PAPER

SUBJECT: Family Advocacy Program (FAP)

1. PURPOSE. To define FAP program goals and procedures to individuals involved through the medical treatment facility (MTF).

2. FACTS.

a. References:

(1) Department of Defense Instruction (DODI) 6400.1, FAP.

(2) Army Regulation (AR) 608-18, FAP, 1 sep 95.

(3) AR 340-21, Army Privacy Program, 5 Jul 85.

(4) Health Services Command Pamphlet 608-1, FAP, 27 Jul 94.

b. The FAP is congressionally mandated and directed from the DOD Office of Personnel and Readiness.

c. The Department of the Army proponent is the Community and Family Support Center in the Office of the Assistant Chief of Staff for Installation Management.

d. The FAP is a dual mission program to prevent and to treat child/spouse abuse. At the local installation level, both the Army Community Service (ACS) and the MTF have roles in prevention. Command and Community education are the responsibility of the ACS. Treatment and case management are the roles of the MTF, to include Social Work Service (SWS).

e. Within the MTF, SWS provides assessments of and counseling for families/individuals seeking assistance. For families reported as having been involved in an abusive instance, SWS coordinates evaluations, examinations, and gathers information to prepare a case staffing to a multi-disciplinary Case Review Committee (CRC) that evaluates the family's need for intervention and assistance.

f. The CRC evaluates the preponderance of indicators/ information to determine if an abusive instance did occur, what factors (problems) contributed to the events, and develops a treatment plan to address all identified problems for all individuals involved, abuser, victim, and child witness to family violence. The objective of the treatment plan is to increase individual and family skills and thereby reduce the potential for violence. Every effort will be made to keep the soldier and family informed on case progress.

g. By regulation, a soldier's commander is advised of the CRC process and invited to attend CRC meetings to add any relevant information about the soldier and family in order to facilitate meeting the soldier's and families needs.

h. By definition, the FAP, is a program to act on behalf of a family; however, should an individual believe that the CRC was inaccurate in determining an abuse status or plan of treatment, he/she may request that the CRC review his/her case a second time.

i. Requests for review are based on the following:

(1) The CRC did not have all relevant information (If the client refuses to provide information during intake and scheduled interviews, and a CRC determination is made that the client believes to be adverse, subsequent requests for case review will not be honored).

(2) The CRC did not follow or comply with published policies or procedures.

j. The request to the team must be made in writing through the MTF commander no more than 30 calendar days after the CRC decision. It must state what relevant information was not available and why or what published policy or procedure was not met. Only one reevaluation request will be considered for each incident. Treatment will not be suspended, interrupted or postponed pending the outcome of the review.

k. The MTF commander forwards the request to the Chief, SWS. The case is assigned to a case manager who reviews the case, interviews the individuals involved and resubmits the case to the CRC with any additional/new information obtained. The CRC reevaluates the case with new information and reaches a case determination.

l. The CRC reviews are documented in the families case file and family/individual and commander are advised in writing of the team's second determination.

m. A review will be conducted only by the CRC which made the determination on the case. If it is not possible for the initiating CRC to review the case, the request will be submitted, with supporting information, directly to the MEDCOM review committee.

Mary W. Behrend/MCHO-CL-H/DSN 471-6767

ACKNOWLEDGMENT OF RECEIPT OF FAMILY ADVOCACY (CRC) PROCEDURES

SPONSOR:

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE FAMILY ADVOCACY (CRC) PROCEDURES FACT SHEET.

_____
Signature

_____
Printed Name

_____
Date

SPOUSE:

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE FAMILY ADVOCACY (CRC) PROCEDURES FACT SHEET.

_____
Signature

_____
Printed Name

_____
Date

APPENDIX K: TREATMENT PLANNING GUIDE

Treatment Planning Guide

Reference: Chapter 5.5 d.
Chapter 6.1 a (2)

This chart is intended to be used as a guide to assist clinicians to develop FAP treatment plans. Treatment plans MUST be assessment driven.

	INTERVENTION OPTIONS	OFFENDER	VICTIM	CHILDREN
LEVEL 1	**A Psychoeducational Classes:**	Assessment Driven (AD)	AD	AD
	1. Communication Skill	AD	AD	AD
	2. Parent Education	AD	AD	
	3. Budget Counseling	AD	AD	
	4. Alcohol Education Awareness	AD	AD	AD
	5. Stress Management	AD	AD	AD
	6. Victim Advocate		AD	AD
	7. Others	AD	AD	AD
	B Treatment Sessions:	1 +	1+	1+
	1. Individual			
	2. Couple			
	3. Family			
	4. County/State mandatory treatment programs	As Required	As Required	As Required
LEVEL 2	A. Psychoeducational Classes:	AD	AD	AD
	1. Communication Skill	AD	AD	AD
	2. Parent Education	AD	AD	
	3. Financial Management.	AD	AD	
	4. Alcohol Education Awareness	AD	AD	AD
	5. Stress Management	AD	AD	AD
	6. Victim Advocate		AD	AD
	7. Conflict Management	AD	AD	AD
	8. Pre-marital Counseling	AD	AD	AD
	9. Children who Witness Violence	AD	AD	AD
	B. Treatment Sessions:	4 +	AD	AD
	1. Individual/Adult and Child			
	2. Couple/Marital			
	3. Group-Gender Specific			
	4. Group-Couples			
	5. Group-Age Based Child			
	6. Family			
	7. County/state mandatory treatment programs	As Required	As Required	As Required

Minimum number of treatment sessions may include one or any combination of listed modalities.

	INTERVENTION OPTIONS	OFFENDER	VICTIM	CHILDREN
LEVEL 3	A. Psychoeducational Classes:	AD	AD	AD
	1. Communication Skill	AD	AD	AD
	2. Parent Education	AD	AD	
	3. Budget Counseling	AD	AD	
	4. Alcohol Education Awareness	AD	AD	AD
	5. Stress Management	AD	AD	AD
	6. Victim Advocate		AD	AD
	7. Others	AD	AD	AD
	B. Treatment Sessions:	12 +	1+	1+
	1. Individual/Adult and Child			
	2. Couple/Marital			
	3. Group-Gender Specific			
	4. Group-Couples			
	5. Group-Age Based Child			
	6. Family			
	7. County/State mandatory treatment programs	As Required	As Required	As Required
LEVEL 4	A. Psychoeducational Classes:	AD	AD	AD
	1. Communication Skill	AD	AD	AD
	2. Parent Education	AD	AD	
	3. Budget Counseling	AD	AD	
	4. Alcohol Education Awareness	AD	AD	AD
	5. Stress Management	AD	AD	AD
	6. Victim Advocate		AD	AD
	7. Others	AD	AD	AD
	B. Treatment Sessions:	26 +	1+	1+
	1. Individual/Adult and Child			
	2. Couple/Marital			
	3. Group-Gender Specific			
	4. Group-Couples			
	5. Group-Age Based Child			
	6. Family			
	7. County/State mandatory treatment programs	As Required	As Required	As Required

Minimum number of treatment sessions may include one or any combination of listed modalities.

	INTERVENTION OPTIONS	OFFENDER	VICTIM	CHILDREN
LEVEL 5	A. Psychoeducational Classes:		AD	AD
	1. Communication Skill	N/A	AD	AD
	2. Parent Education	N/A	AD	
	3. Budget Counseling	N/A	AD	
	4. Alcohol Education Awareness	N/A	AD	AD
	5. Stress Management	N/A	AD	AD
	6. Victim Advocate		AD	AD
	7. Others	AD	AD	AD
	B. Treatment Sessions:		AD	AD
	1. Individual/Adult and Child	AD (Non-FAP)	AD	AD
	2. Couple/Marital	N/A	AD	
	3. Group-Gender Specific	N/A	AD	AD
	4. Group-Couples	N/A	AD	
	5. Group-Age Based Child	N/A		AD
	6. Family	N/A	AD	AD
	7. County/State mandatory treatment programs	As Required	As Required	As Required

Minimum number of treatment sessions may include one or any combination of listed modalities.

APPENDIX L: CHILDREN WHO WITNESS DOMESTIC VIOLENCE

- **Impact of Spouse Abuse on Children of Battered Women: Implications for Practice (H. Hughes)**
- **Children: The Unintended Victims of Marital Violence (A. Rosenbaum/K. O'Leary)**

Reference: Chapter 5.4.1

This section includes information about the effects of witnessing domestic violence on children, and on treatment modalities for these children.

NOTES

MCHG-SW 12 JULY 1995

MEMORANDUM FOR: Mrs. Mary Behrend

SUBJECT: Children who witness violence and treatment modalities

1. Effect of Witnessing domestic violence on Children: Children imitate what they see, they perpetuate the violent relationships that they witness, are much more likely to become violent in their relationships and to rely on violence as a problem solving method. They learn unhealthy communication skills, are more likely to develop characterological and long term emotional problems, especially in areas of trust.

2. Process of Treatment for group, individual and couple counseling.

   a. Assessment (offender, victim, children and/or family members). Will be ongoing and performed during each stage.

   b. Engagement/Rapport Building (Therapeutic relationship). Assisting the Patient to become familiar with the treatment process, the treatment provider's style, comfort with the goals and objectives of the process, and trust building within the relationship. Is an integral part of the entire process and should be considered throughout.

   c. Psychoeducation (didactics) provides knowledge and information for the client to gain insight into their environment, relationships, behavior, and internal motivation. Not therapeutic in nature.

   d. Behavioral and Cognitive Reframing and Restructuring (the former: a change in perspective and view of the self. The latter: changing the thought process to decrease negative patterns and images and replace them with positive ones.) Through this process the client gains new insight and is able to make changes in behaviors and cognitive thought processes, which lead to internal changes in self esteem and confidence. The learning process identifies to, then educates, the individual in new coping strategies.

   e. Integration (Utilize new skills and thought processes in daily functioning). They become a part of the individual's concept of self. It becomes a matter of routine for the individual to accept these new coping strategies and skills.

   f. Accountability: This is another part of the process that should be well integrated into treatment. Each Offender must be held responsible for for his/her behavior and/or perspective. There must be enforceable consequences, and they must be followed through with each instance. This is the part of the process that becomes the motivation for change. Without this, there can be no success. Contrary to popular belief, it is my opinion that there must be built into the system a reasonable counterpart to this accountability for the Victim. He/she must be "motivated" by a similar system where they will be mandated to receive treatment and education and be unable to refuse. The benefits to this far outweigh the uneasy feeling

many social workers get when they think they must tip toe around the victim. This person is responsible for their own recover and self esteem. They must become motivated to stop being a victim and learn to appreciate themselves to the degree that they will no longer tolerate victimization.

g. Termination

h. Recidivism: An issue that requires more study. There are many beliefs and opinions concerning the best way to decrease or eliminate this. The bottom line, however, is that the only way to stop violent behavior rests with the offender. Without enforcement of consequences for the offender, there will be no change in behavior. In addition to mandated counseling and education, there may be hope to decrease the number of subsequent incidents. The area for further study lies in discovering the most effective type of intervention. One important variable to examine in the study, would be to closely monitor progress with a formalized follow up strategy, throughout the intervention period and for a time beyond.

3. Colorado Domestic Violence Standards mandate that marital therapy will not be utilized until 7 months after the offender has begun treatment and that certain behavioral criteria has been fulfilled: e.g. taking responsibility, absence of subsequent incidents and threat, etc. However, we do recommend communication skill workshop which is didactic, and not therapeutic, in all cases where couples continue to cohabitate unless clinically contraindicated (especially if the victim continues to be abused).

4. For offenders there is twelve weeks of psychoeducation before entering the therapy phase of group treatment, group therapy then continues for a minimum of 24 weeks. For victims there is twelve weeks of psychoeducation followed by a minimum of 24 weeks of group therapy. Individual therapy is planned for victims and offenders on a case by case basis. Marital counseling follows completion of the Colorado Domestic Violence Standards on a case by case basis. Cases not involved in the legal system are assessed for marital counseling on individual basis in place of the Standard treatment.

5. For sexual offender Colorado Standard are for two years of group therapy. Most sex offender programs already require polygraph exams in assessment and as part of the ongoing evaluation of potential for re-offending. The Colorado standards for use of polygraph will be complete within 12 to 18 months. There is no information currently available on including polygraphs in cases of domestic violence and domestic violence programs currently do not use them. It is our belief that this must be considered a valuable tool for assessing the risk for re-offense, the offender's progress in treatment and the validity of the offender's statements of goals and attitude. Although this is a very debatable issue the majority of the treatment staff feel that the polygraph should be used in all Domestic Violence cases. Consequently, I recommend the polygraph be administered to all offenders of Domestic Violence.

LEON C. SCOTT
LTC, MS
Chief, Social Work Service

enc.

APPENDIX M: VICTIM ADVOCATE

Job Description: Victim Advocate

Reference: Chapter 4.2 a (8)

This section includes a sample job description for a Victim Advocate.

JOB DESCRIPTION VICTIM ADVOCATE

INTRODUCTION

This position is located within the Family Advocacy Program (FAP) at the Army Community Service (ACS), _____. The primary purpose of this position is to provide comprehensive assistance and liaison to and for victims of spouse abuse; and to educate personnel on the installation regarding the most effective responses to domestic violence on behalf of victims and at-risk family members.

MAJOR DUTIES AND RESPONSIBILITIES

1. Screens victims of spouse abuse, evaluates their needs, and provides them with information about domestic violence, safe and confidential ways to seek assistance, their rights as Army spouses, and the resources and services available to them. This involves maintaining current information on resources and services, and advising victims before disclosure of the limited confidentiality rule.

2. Coordinates with case manager in developing appropriate plan of assistance/intervention which provides for the safety of the victim and their family members. When FAP case managers are not on duty, this may involve working with law enforcement and/or the sponsoring command. This involves decisions affecting a wide range of problems and services, some of which are quite difficult.

3. Non-voting members of the Case Review Committee.

4. Provides services for victims of spouse abuse and their families to include the following: crisis intervention; assistance in securing medical treatment for injuries; information on legal rights and resources available through both military and civilian programs; education; transportation; pre-trial, trial, and post-trial support; and, follow-up. Assists in conducting support groups for victims. Make referrals to other helping agencies. Provides follow-up to all identified victims (to include those who have declined services) three months following initial contact to ensure that no further intervention is necessary.

5. Maintains a notebook of contacts and referrals. Ensures that case manager is fully aware of victim's situation and requests necessary entries be made by case managers into appropriate case record. Ensures confidential handling of all documents or conversations relative to victim care.

6. Advocates for the expressed interest and safety of the victim when providing testimony in the court martial or civilian judicial system.

7. Understands and anticipates the nature of the position requiring some off-duty hour requirements, to include a 24-hour duty rotation.

cise good personal judgment in the application of procedures to cases. Actions taken in particular cases must be consistent with the plans of the professional social workers or a counselor who is the case manager. The supervisor maintains a close operational control of decisions and services when the incumbent is dealing with serious problems demanding unusual skill and judgment.

FACTOR 3. GUIDELINES

Guidelines include DoD Directives, Army Regulations, state and local laws pertaining to criminal domestic violence, other materials and professional standards appropriate to the various fields of human services, the ACS and FAP standard operating procedures and direction from the C, SWS. The incumbent should have the ability to interpret these regulations and should be capable of using sound judgment in following them. Issues in the FAP are very sensitive in nature and require a great degree of confidentiality.

FACTOR 4. COMPLEXITY

The Victim Advocate, while receiving some instruction, must analyze many factors in each case so as to seek out those resources which are critically needed and most likely to be responsive. The incumbent must be able to take initiative in responding to cases and effectively understand the problem or interrelationship of problems, work through them with the client to reach workable, satisfactory resolutions. She-he must also be able to prepare and present briefings to all levels of the command structure.

FACTOR 5. SCOPE AND EFFECT

The incumbent assists professional social work and counseling staff in providing assistance to victims of domestic violence. This includes interfacing with both military and civilian medical, legal, social service, criminal justice systems. In providing education and training on domestic violence, the incumbent impacts on the command at large. Both functions relate directly to the well-being of military personnel and their families and in turn affects their morale and productivity, and the Command's readiness.

FACTOR 6. PERSONAL CONTACTS

The incumbent has contacts with diverse individuals and groups. Contacts include psychologists, unit commanders, clients, physicians, dentists, professional educators, chaplains, social workers, state and local government agencies, probation officers, police officers, lawyers and judges. These contacts are highly sensitive and require discretion, diplomacy and experienced professional expertise, and the ability to quickly bring knowledge to bear in a problem situation.

FACTOR 7. PURPOSE OF CONTACTS

The purpose of contacts is to protect victims in crisis, establish, ensure, and carry out effective cooperative relationships with both the military and civilian communities; exchange information; coordinate activities and services; discuss, advise and solve case a program problem; and, to provide education and training to prevent domestic violence.